

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9001
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MAX HEFFNER

2. DATE
OF
DEATH

10-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

1933 W. North Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

1933 W North Ave

c. Length of stay in Baltimore

50

Yrs.
Mths.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (in years

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

58

10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Shoe maker

10b. KIND OF BUSINESS OR
INDUSTRY

SEWING

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Benjamin

14. MOTHER'S MAIDEN NAME

Ethel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ethel Heffner - Jane

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST,

(B)

DUE TO

Coronary Artery Disease

(C)

DUE TO

2 yrs.

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT

WORK ☐

NOT WHILE

AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/26 3:00 PM 4/10 10/20, 1950, that I last saw the
deceased alive on 10/20, 1950 and that death occurred at 3:00 PM, from the causes and on the date stated above.

23a. SIGNATURE

Edward A. Kaelins

M. D.

23b. ADDRESS

1847 W. Knott Dr

23c. DATE SIGNED

10/20/50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

Burial 10-22-50

Rose Dale

Balto

Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 22 1950

VS 150

Jesse L. Smith 2100 Eutaw Pl

582 FE

0942

Kullius
1847 W North

B-240

50 9002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. 9002

1. NAME OF DECEASED
(Type or Print)

Mrs. Julia Elizabeth Bokel

2. DATE
OF
DEATH

October 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

9-08

D. STREET ADDRESS (If rural, give location)

707 Bartlett Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Fe.

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/28/1895

9. AGE (In years
last birthday)

55

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Hwfe.

10B. KIND OF BUSINESS OR
INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Emil Preis

14. MOTHER'S MAIDEN NAME

Katie Weiss

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Wm Bokel 707 Bartlett Ave

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple embolism
arteriosclerotic cardiac disease with multiple
myocardial infarctions

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertension

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK22. I hereby certify that I attended the deceased from 10/5/1950, to 10/20/1950 that I last saw the
deceased alive on 10/20/1950 and that death occurred at 3:00 PM., from the causes and on the date stated above.

23A. SIGNATURE

Maddens Swinski

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

10/20/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

10/23/50

24C. NAME OF CEMETERY OR CREMATORY

Morningside Park

24D. LOCATION (City, town, or county)

Parkville Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm Bokel Inc. 1217 St. Paul St.

VS 150

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

1948



R-262
50 9003BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9003

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William M. Rogers

2. DATE
OF
DEATH

October 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

4123 Buena Vista Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4123 Buena Vista Avenue

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Aug. 1872

9. AGE (In years
last birthday)

78

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Ret. Coal Miner

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

George Lane, 4123 Buena Vista Avenue

18.

420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Arterio-sclerotic coronary artery
Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 8, 1950, to 20 Oct, 1950 that I last saw the
deceased alive on 19 Oct, 1950, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Samuel Schepfer M.D.

23B. ADDRESS

714 E. Preston St

23C. DATE SIGNED

20 Oct 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

10/23/50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county)

Baltimore,

Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Wm Cook, Inc.,

1217 St. Paul Street

094a

3003

OK

3003

OK



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

IDA MARGARET SCHILLINGER

2. DATE
OF
DEATH

OCT. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE

MD.

B. COUNTY

Harford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

JOPPA, MD.

D. STREET ADDRESS (If rural, give location)

JOPPA, MD.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

6200

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

OCT. 18, 1881

9. AGE (In years
last birthday)

69 68

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN JOHNSON

14. MOTHER'S MAIDEN NAME

MARY J. HAYGHE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

(If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

PATIENT

ADDRESS

18. 454X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

PULMONARY EMBOLISM

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

AURICULAR THROMBUS (RT.)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

-

-

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

MULTIPLE KIDNEY CYSTS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from SEPT. 23, 1950, to OCT. 21, 1950, that I last saw the
deceased alive on OCT. 21, 1950, and that death occurred at 6:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

10-21-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

OCT 23, 1950

24C. NAME OF CEMETERY OR CREMATORY

Providence

24D. LOCATION (City, town, or county)

Tollaton Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 22 1950

REGISTRAR'S SIGNATURE

Christy J. Williams

25. FUNERAL DIRECTOR

9 Archer

ADDRESS

Benson

1000

06

1000

06



F-260

50

9005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X

50

9005

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Frank B. Fisher

2. DATE
OF
DEATH Oct. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

none Talbot

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

4415 Marble Hall Road

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give
Baltimore Neavitt township)

D. STREET ADDRESS (If rural, give location)

Neavitt, Maryland

7000

C. Length of stay in Baltimore

6 weeks

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

May 5, 1884

9. AGE (In years
last birthday)

66

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

waterman

10B. KIND OF BUSINESS OR
INDUSTRY

Fisherman

11. BIRTHPLACE (State or foreign country)

Neavitt, Md.

12. CITIZEN OF
WHAT COUNTRY?
U. S.

13. FATHER'S NAME

Levin T. Fisher

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Frank E. Fisher 4415 Marble Hall Rd.

18. 157x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Carcinoma - Pancreas

INTERVAL BETWEEN
ONSET AND DEATH

1 year.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

9-26-50

19B. MAJOR FINDINGS OF OPERATION

Cancer of Pancreas, Intestinal Obstruction

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Sept. 10, 1950, to Oct. 21, 1950, that I last saw the
deceased alive on 10-20, 1950, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Arthur Karfagi

M. D.

23B. ADDRESS

4230 Rock Raven Blvd.

23C. DATE SIGNED

10-21-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

10/24/50

24C. NAME OF GEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

Neavitt, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

10/25/50

25. FUNERAL DIRECTOR

Harrison & Newnam

ADDRESS

St. Michael's, Md.

VS.150

910 12

0469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully specified. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

S-530
50 9006BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Baxter Smith

2. DATE
OF
DEATH

10/31/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Woodbury Fred Md

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTIONUNIVERSITY HOSPITAL
Sgt. Walker

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

6000

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1880

9. AGE (In years
last birthday)

70

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Labor Farm

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Wm A. Smith

14. MOTHER'S MAIDEN NAME

Annabell. Cutshall.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

G. Borton Walkersville

ADDRESS

18.

150X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of Upper Esophagus

6 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Mediastinal metastases

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10/1/50

19B. MAJOR FINDINGS OF OPERATION

Inoperable Carcinoma upper 1/2 Esophagus

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/23, 1950, to 10/21, 1950, that I last saw the
deceased alive on 10/21, 1950, and that death occurred at 12:30 m., from the causes and on the date stated above.

23A. SIGNATURE

Charles James Anderson

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

10/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 24

24C. NAME OF CEMETERY OR CREMATORY

Int Hope

24D. LOCATION (City, town, or county)

Woodbury Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

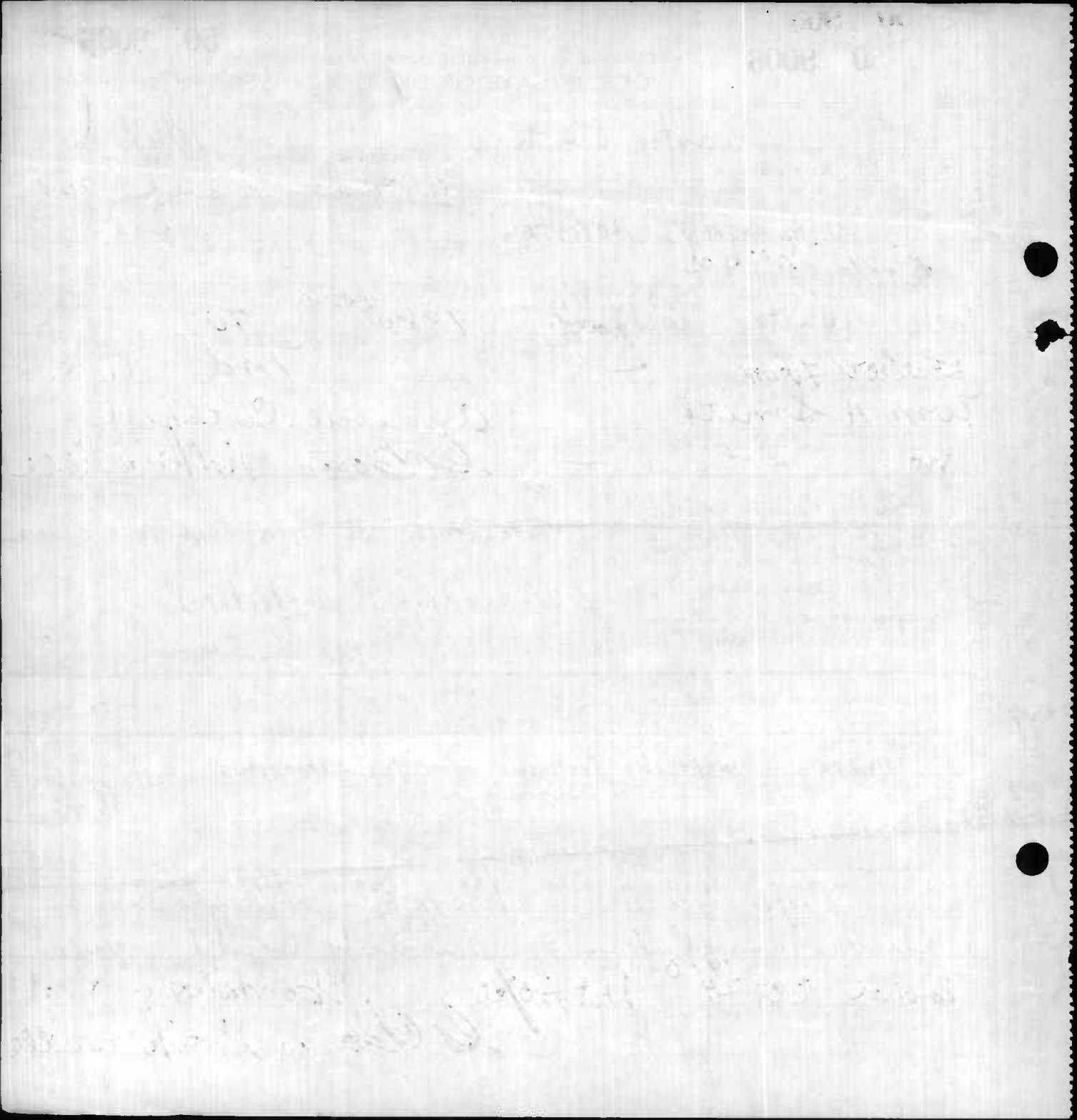
G. Borton Walkersville

OCT 22 1950

f2010

046a

MARGIN RESERVED FOR BINDING
PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



y-520
50 9007BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9007
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mr William Young

2. DATE
OF
DEATH

20 Oct 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

Church Home & Hosp

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

1-02

D. STREET ADDRESS (If rural, give location)

509 South Lenwood Ave

c. Length of stay in Baltimore

40

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

male

white

married

8. DATE OF BIRTH

2 Sept 1881

9. AGE (In years
last birthday)

69

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

watch maker ENGINEER

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William Young

14. MOTHER'S MAIDEN NAME

Catherine Kerw

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

215-18-7658

17. INFORMANT

ADDRESS

Sadler, Mrs Mary 131 North Potomac St.

18. 151X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Adenocarcinoma of the Stomach 5 months

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

20 July 50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Stomach & Metastasis

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 19 Oct., 1950 to 20 Oct., 1950, that I last saw the
deceased alive on 19 Oct., 1950, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Doreen C. Lush

23B. ADDRESS

Church Home & Hosp Bldg 20 Oct 50

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10/23/50

Holy Redeemer Cem.

Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

John A. Moran 3000 E. Balto. St.

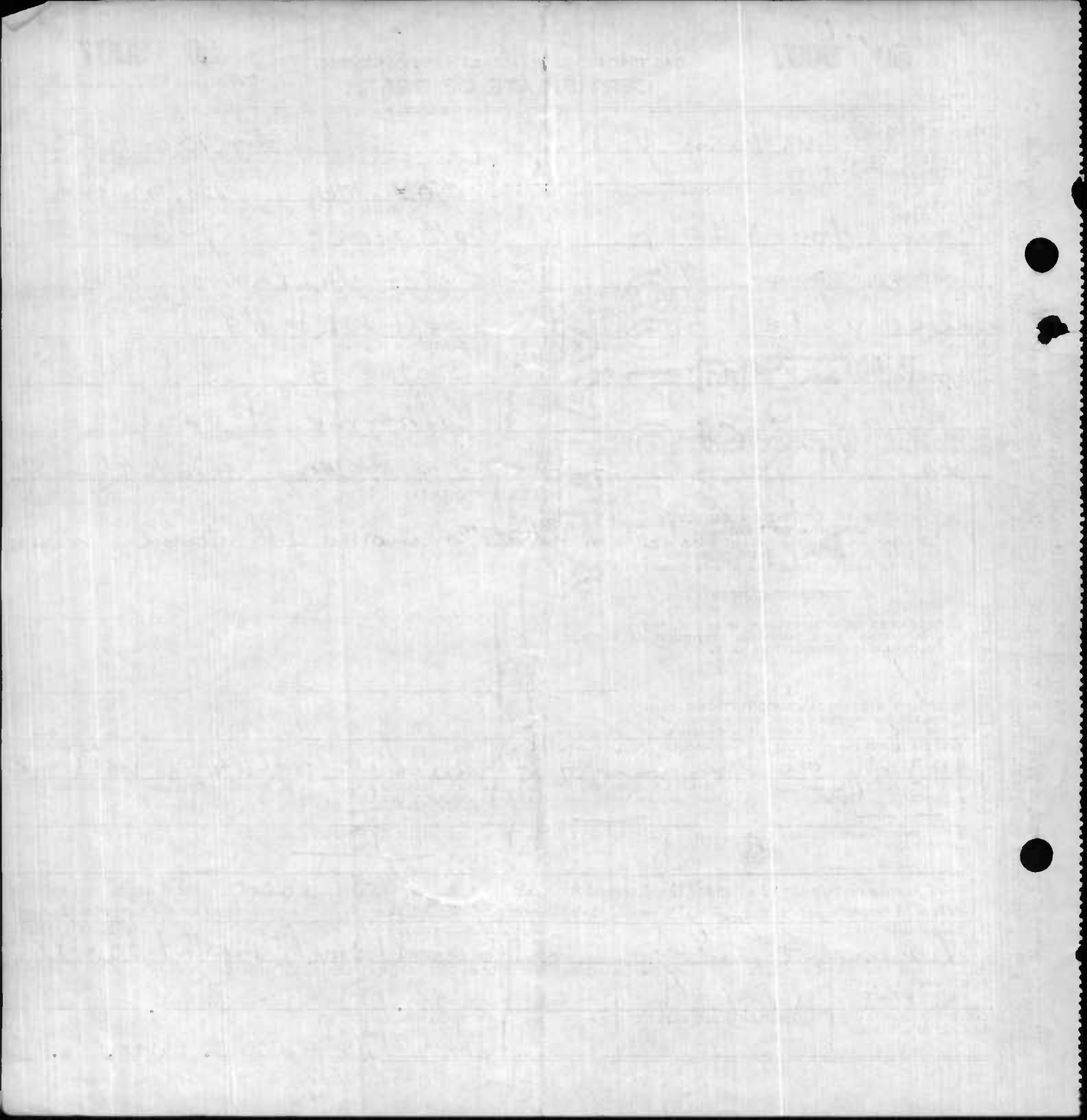
VS 150

240 555

H&K

0466

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



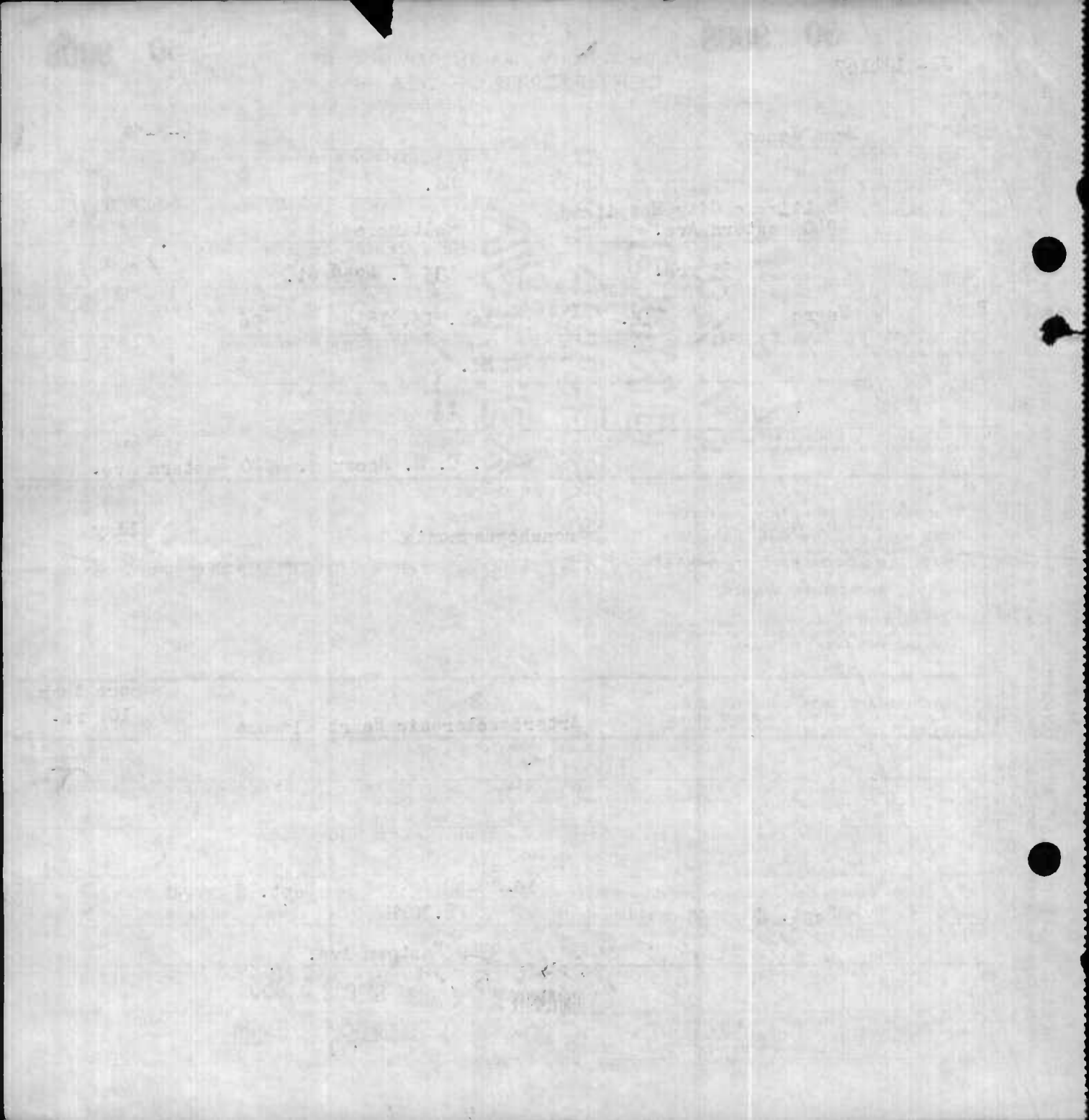
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-5280 9008
JL-124167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9008
Registered No. _____

BIRTH NO. _____	
1. NAME OF DECEASED (Type or Print) Emma Jones	
2. DATE OF DEATH 9-8-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.	
C. LENGTH OF STAY IN BALTIMORE 55 yrs.	
5. SEX F	6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.	
8. DATE OF BIRTH Feb. 15, 1854	
9. AGE (in years last birthday) 96	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Ma.	
12. CITIZEN OF WHAT COUNTRY? Ma.	
13. FATHER'S NAME ?	
14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT B. C. H. Records, 4940 Eastern Ave.	
ADDRESS	
18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Bronchopneumonia DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart disease more than 10 yrs.	
19A. DATE OF OPERATION ✓	
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-29-48 , 19__, to Sept. 8 , 19 50 , that I last saw the deceased alive on Sept. 8 , 19 50 and that death occurred at 8.30 PM. , from the causes and on the date stated above.	
23A. SIGNATURE W. C. Crozen M. D.	
23B. ADDRESS 4940 Eastern Ave.	
23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify)	
24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR OCT 22 1950	
REGISTRAR'S SIGNATURE W. C. Crozen	
25. FUNERAL DIRECTOR University Medical School	
ADDRESS	



ES-140935

50

9009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

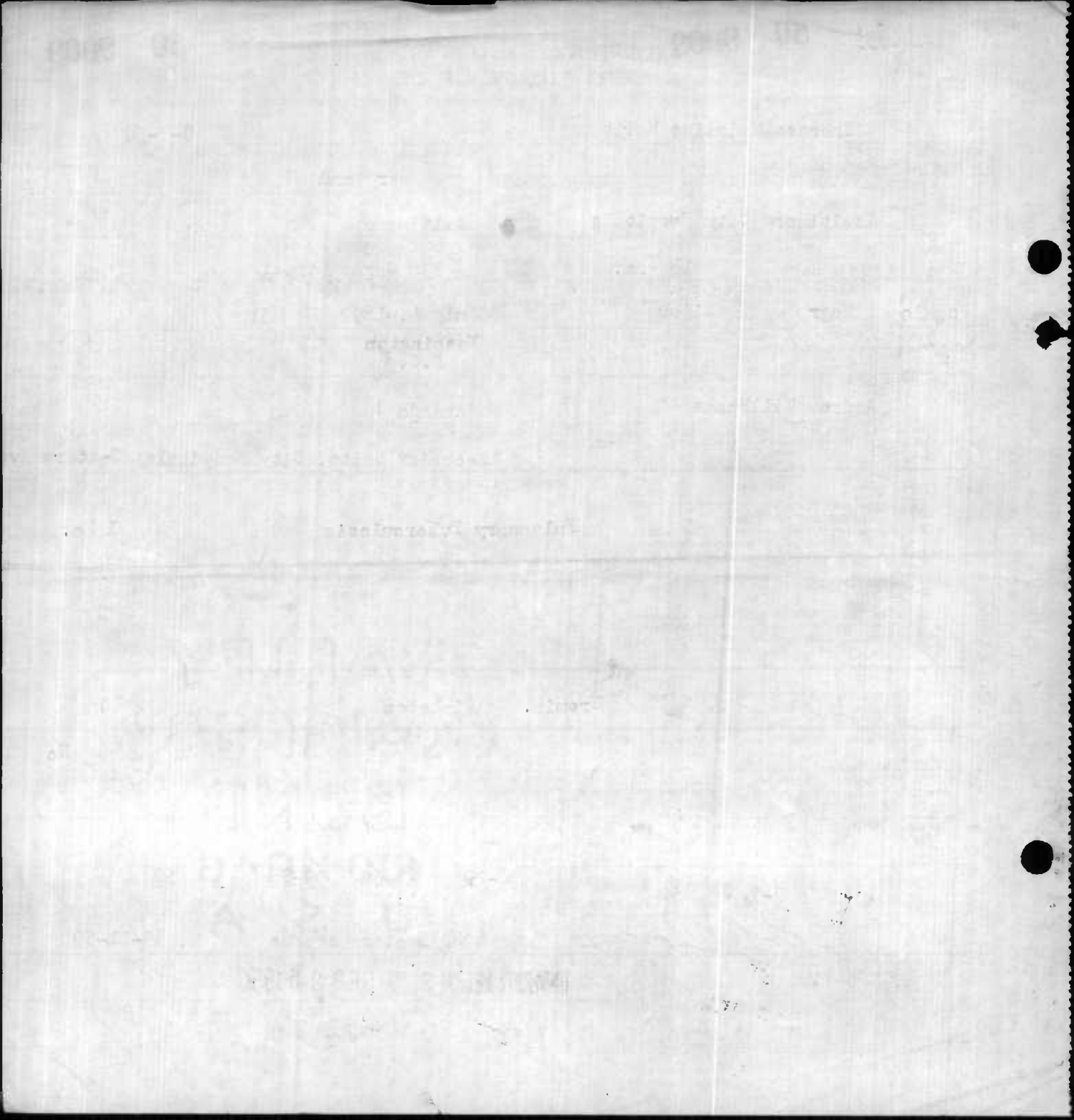
9009

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Theresa Madeline Mills			2. DATE OF DEATH 9-9-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 18 Yrs. Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 236 Carey Street 19-02		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July 4, 1899		9. AGE (In years last birthday) 51
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Andrew Willbanks			14. MOTHER'S MAIDEN NAME Amanda ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Records* Balto. City Hospitals Eastern Ave ADDRESS 4940		
18. 002X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis CAUSE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Uremia. Diabetes			INTERVAL BETWEEN ONSET AND DEATH 1 Mo.		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-23 , 19 50 , to 9-9 , 19 50 , that I last saw the deceased alive on 9-9 , 19 50 , and that death occurred at 11:10 a.m. from the causes and on the date stated above.					
23A. SIGNATURE P. S. Dozen M. O.		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 9-11-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	
DATE RECEIVED BY LOCAL REGISTRAR SEP 22 1950		REGISTRAR'S SIGNATURE Huntington		25. FUNERAL DIRECTOR Commissioner of Health	
VS 150				ADDRESS	

0136



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9010

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GIBSON/CHAS. Lyman

2. DATE
OF
DEATH

9/11/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

Md.

D. STREET ADDRESS (If rural, give location)

2101 W. Gold Spring Lane

5. SEX

M.

6. COLOR OR RACE

C.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

Yrs.
Mos.
Days

40 yrs.

8. DATE OF BIRTH

1/21/81

9. AGE (In years, if Under 1 Year, last birthday; Months; Days; Hours; Min.)

69

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Surgical Worker

10B. KIND OF BUSINESS OR INDUSTRY

UNKNOWN

11. BIRTHPLACE (State or foreign country)

British Guinea

12. CITIZEN OF WHAT COUNTRY?

England

13. FATHER'S NAME

Samuel Gibson

14. MOTHER'S MAIDEN NAME

Elizabeth Oudkirk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, do or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Elizabeth Williams 2101 W. Gold Spring

18. 163X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

CARCINOMA OF LUNG

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Metastasis

9 mos.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 7/11, 1950, to 9/11, 1950, that I last saw the deceased alive on 9/9, 1950, and that death occurred at 3:29 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

50 9011
S-322BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9011
Registered No.

1. NAME OF DECEASED (Clarence or Lewis) Eddie Stokes			2. DATE OF DEATH Sept. 14, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-02		
D. STREET ADDRESS (If rural, give location) 808 E. Lexington St.			E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS	

18. 4221 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES		
(B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley K. Dunleavy M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Sept. 15, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATOR, AND LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	

1100

05

1100

05

CERTIFICATE OF DEATH

DEC 1 1900

5-36350 9012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9012

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Walter Stewart

2. DATE
OF
DEATH

Aug 26 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived, if institution: residence
A. STATE U B. COUNTY before admission)B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
K township)

D. STREET ADDRESS (If rural, give location)

O

14-02

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years
last birthday)

N

55?

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. 600.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Acute Pyelonephritis
= Uremia

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. ...

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Aug 27 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL SEP 1 1950
Commissioner of Health

20 0015

20 0015

CERTIFICATE OF DEATH

Number 24-1000

From 24-1000-1

State of California

20 0015

J-525
50 9013
BIRTH NO. 50-25062BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9013
Registered No.

1. NAME OF DECEASED (Type or Print) BABY			2. DATE OF DEATH SEPTEMBER 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) 906 Peach Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-01		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 906 Peach Street		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH U	9. AGE (In years last birthday) 2	If Under 1 Year Months: 2 If Under 24 Hours Hours: 2 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) K		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME K			14. MOTHER'S MAIDEN NAME O		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) U		16. SOCIAL SECURITY NO.	17. INFORMANT N ADDRESS		

18. CAUSE OF DEATH 754.2 N DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Congenital heart disease (B) (Interventricular septal defect) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William V. Smith</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 9-5-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24B. DATE 9/25/50	24C. NAME OF CEMETERY OR CREMATORY Balto. City Morgue	24D. LOCATION (City, town, or county) (State) 700 Fleet St. Balto Md		
DATE RECEIVED BY LOCAL REGISTRAR OCT 22 1950		REGISTRAR'S SIGNATURE <i>William V. Smith</i>		25. FUNERAL DIRECTOR Thurmond S. Fisher	

NO 8013

20 8013

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

REGISTRATION

1

DEATH OF

1913



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-4635 9014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9014
Registered No.

BIRTH NO. 50-25694

1. NAME OF DECEASED (Type or Print) BABY BELTON			2. DATE OF DEATH August 10, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Provident Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 510 Oxford Street		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U	8. DATE OF BIRTH U	9. AGE (In years last birthday) 1	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY K		11. BIRTHPLACE (State or foreign country) K	
13. FATHER'S NAME N		14. MOTHER'S MAIDEN NAME O			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N		17. INFORMANT W ADDRESS	

18. 760.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Intracranial hemorrhage due to birth trauma	INTERVAL BETWEEN ONSET AND DEATH
ANCECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>Stanley H. Williams, M.D.</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED August 23, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) cremation		24B. DATE 9/25/50		24C. NAME OF CEMETERY OR CREMATORY Balto. City Morgue	
24D. LOCATION (City, town, or county) (State) 700 Fleet St. Balto. Md		25. FUNERAL DIRECTOR Russell S. Fisher		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR OCT 22 1950		REGISTRAR'S SIGNATURE <i>William Williams</i>			

Thrown in Furnace at Morgue

1600a

50 2014

STATE OF OHIO
DEPARTMENT OF REVENUE

50 2014

50 9015

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9015

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Warren

R.

HAWKINS

2. DATE
OF
DEATH

Sept. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1122 Lombard St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Unknown

8. DATE OF BIRTH

Unknown

9. AGE (In years
last birthday)

57

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Hypertensive Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Pulmonary Emphysema

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

M. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Stanley B. Dunleavy

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Sept. 21, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

30 3015

30 3015

STATEMENT OF DEATH

DEATH OF DEATH

DEATH OF DEATH

DEATH OF DEATH

DEATH OF DEATH

DEATH OF DEATH

DEATH OF DEATH

W-230
50 9016BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9016
Registered No. 39376 1/2

BIRTH NO. 50-20069			
1. NAME OF DECEASED (Type or Print) Baby Boy West		2. DATE OF DEATH 9/20/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balt.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt. 14-03	
D. STREET ADDRESS (If rural, give location) 1819 E. St.			
c. Length of stay in Baltimore 1		8. DATE OF BIRTH 9/19/50	
5. SEX m	6. COLOR OR RACE c	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) s	9. AGE (In years last birthday) 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles Forrest	
14. MOTHER'S MAIDEN NAME Shirley West		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) o	
16. SOCIAL SECURITY NO.		17. INFORMANT Shirley West	
18. 760.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
(A) Cerebral damage		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO			
ANTECEDENT CAUSES			
(B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Prematurity	
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/19, 1950, to 9/20, 1950, that I last saw the deceased alive on 9/20, 1950, and that death occurred at 8:50 P.M., from the causes and on the date stated above.			
23a. SIGNATURE J. E. Juman		23b. ADDRESS University Hospital	
23c. DATE SIGNED 9/20/50			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
25. FUNERAL DIRECTOR		ADDRESS	

CERTIFICATE OF DEATH

STATE OF TEXAS

Age

DECEASED

R-250
50 9017BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9017

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

BESSIE ROSEN

2. DATE
OF
DEATH

10-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

2518 Loyola Southway

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore, 15-13

township)

D. STREET ADDRESS (If rural, give location)

2518 Loyola Southway

C. Length of stay in Baltimore

40 E

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (In years last birthday)

72

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Hyman

14. MOTHER'S MAIDEN NAME

Leina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Joseph Rosen - Same

18. 260X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-21-50, to 10-21, 1950, that I last saw the deceased alive on 10-21, 1950, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

M. E. Needle M.D.

23B. ADDRESS

7318 - 21. North Tyme

23C. DATE SIGNED

10-22-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-22-50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county)

Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

Jack Lewicki 2100 Canton Pl

OCT 22 1950

VS 150

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6006
Pard
Hats

DORN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9018

Registered No. _____

BIRTH NO. 50-224981. NAME OF DECEASED
(Type or Print)Baby Brydon A2. DATE
OF
DEATH10-3-58

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTIONUniversity

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 28-01

D. STREET ADDRESS (If rural, give location)

4313 Eldon Ave

c. Length of stay in Baltimore

4 1/2
Yrs
200
Days

5. SEX

M

6. COLOR OR RACE

W7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)S

8. DATE OF BIRTH

9-30-00

9. AGE (In years, last birthday)

If Under 1 Year
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ind.12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Abraham ~~Leah~~ Dorn

14. MOTHER'S MAIDEN NAME

Anne Lerin15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Anne Dorn.18. 776xDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

CAUSE OF DEATH

PrematurityINTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-3, 1958, to 10-3, 1958, that I last saw the deceased alive on 10-3, 1958, and that death occurred at 3:42 m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. H. A. Dorn

23B. ADDRESS

University Hospital

23C. DATE SIGNED

10-20-5824A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Dr. H. A. Dorn

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

OCT 22 1958

159.0

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L-2650 9019

LEASED BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9019

Registered No. _____

BIRTH NO. 50-21095

1. NAME OF DECEASED
(Type or Print)

Baby John J. J. J.

2. DATE
OF
DEATH

10/8/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

7 days

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

758 W. Baltimore St.

5. SEX

Female

6. COLOR OR RACE

col.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

10/1/50

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

U. S.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Henry Tyler

14. MOTHER'S MAIDEN NAME

Shirley J. J.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

758 W. Baltimore St.

18. 5701

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) peritonitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) perforation of colon

DUE TO

(C) secondary to mesenteric ileus

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ ND ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from 10/1/50, 19__, to 10/8/50, 19__, that I last saw the
deceased alive on 10/8, 1950, and that death occurred at 7:00 P. M., from the causes and on the date stated above.

23A. SIGNATURE

A. T. J. J.

23B. ADDRESS

Univ. Hospital

23C. DATE SIGNED

10/9/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL OCT 11 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

what was supposition of color due to?

See Document File 50-9019

10-27-50

ES.

C-636
50 9020BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9020

Registered No.

BIRTH NO. 50-20646

1. NAME OF DECEASED
(Type or Print)

Baby Boy Carter

2. DATE
OF
DEATH

9-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

University Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Barto 20-01

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1907 Mulberry St.

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9-24-50

9. AGE (In years
last birthday)10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.

5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Linwood E CARTER

14. MOTHER'S MAIDEN NAME

Rosena Carter CHASE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Linwood Carter

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 9-25-50, 1950, to 9-29-50, 1950, that I last saw the deceased alive on 9-29-50, 1950 and that death occurred at 2 P.m., from the causes and on the date stated above.

23A. SIGNATURE

J. A. A. M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

9-29-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 1 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

CARTER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9021
Registered No.

BIRTH NO. 50-28819

1. NAME OF DECEASED (Type or Print) BABY STRONG		2. DATE OF DEATH October 6, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-06	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 4823 O'Donald Street	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Oct. 6, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 2-3	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Myrtle Strong	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. **E926.0**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Neglect of newborn**

DUE TO

ANTECEDENT CAUSES

(B) _____

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
home21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
4823 O'Donald Street21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
October 6, 1950 4 p. m.21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒21F. HOW DID INJURY OCCUR?
Ignorance of postnatal care of newborn22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.23A. SIGNATURE
William V. [Signature]23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ M.D. MEDICAL INVESTIGATOR ☐23C. DATE SIGNED
Oct. 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR
OCT 12 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR
Commissioner of Health

ADDRESS

VS 151

N994x

161a

1908

00

RECEIVED BY HEALTH DEPARTMENT
CONTINGENT OF LEAD

1908

10-27-01

See Document File 50-9071

10-27-01

ES.

10

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9022**BIRTH NO. **50-20576**1. NAME OF DECEASED
(Type or Print)**Reisberg Baby Boy**2. DATE
OF
DEATH**10-1-50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Baltr.** B. COUNTY **md. Howard**

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Franklin Square HospC. CITY OR TOWN, (If outside corporate limits, write RURAL and give township)
Marysville, Md.D. STREET ADDRESS (If rural, give location)
Wards Chapel Rd. 6200

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

m.

6. COLOR OR RACE

w.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9-29-50

9. AGE (In years last birthday)

2 days

10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.

2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Leonard Reisberg

14. MOTHER'S MAIDEN NAME

Elise Hofstetter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. **760.5**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Pulmonary atelectasis**2 days**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Prematurity 2 lbs.

II

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cephalohematoma, Subarachnoid hemorrhage

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from **Sept. 20**, 19**50**, to **Oct. 1**, 19**50**, that I last saw the deceased alive on **Sept. 20**, 19**50**, and that death occurred at **10:00** a. m., from the causes and on the date stated above.

23A. SIGNATURE

Robert H. Chambers

M. O.

23B. ADDRESS

Franklin Square Hosp.

23C. DATE SIGNED

10/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL OCT 2 1950

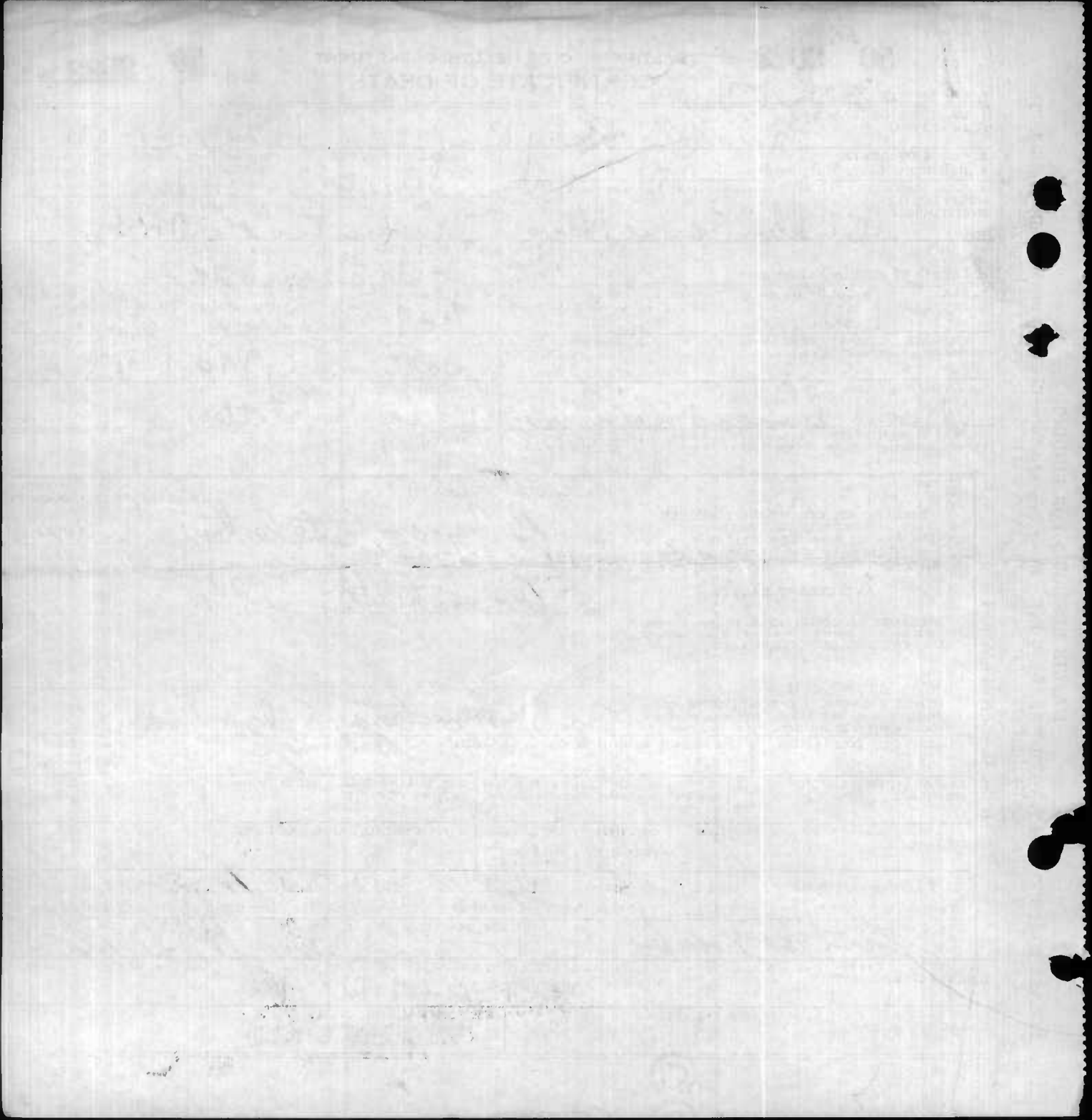
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10/22/50**1950 00009****Commissioner of Health**



G-6130 9023

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9023
Registered No.

BIRTH NO. 50-19070

1. NAME OF DECEASED
(Type or Print)

George Graves

2. DATE
OF
DEATH

9/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 17-01

D. STREET ADDRESS (If rural, give location)

692 Pierce St.

c. Length of stay in Baltimore

4

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

9/9/50

9. AGE (In years
last birthday)10 Under 1 Year
Months Days

4

11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR
INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Alphonso Graves

14. MOTHER'S MAIDEN NAME

Mamie Courts

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

ADDRESS

Hospital chart

18. 754.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Congenital Heart Defect

4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Atelectasis

4 days

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 9-12, 1950, to 9-13, 1950, that I last saw the
deceased alive on 9-13, 1950, and that death occurred at 10:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

M. E. Duszynette

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

9-14-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

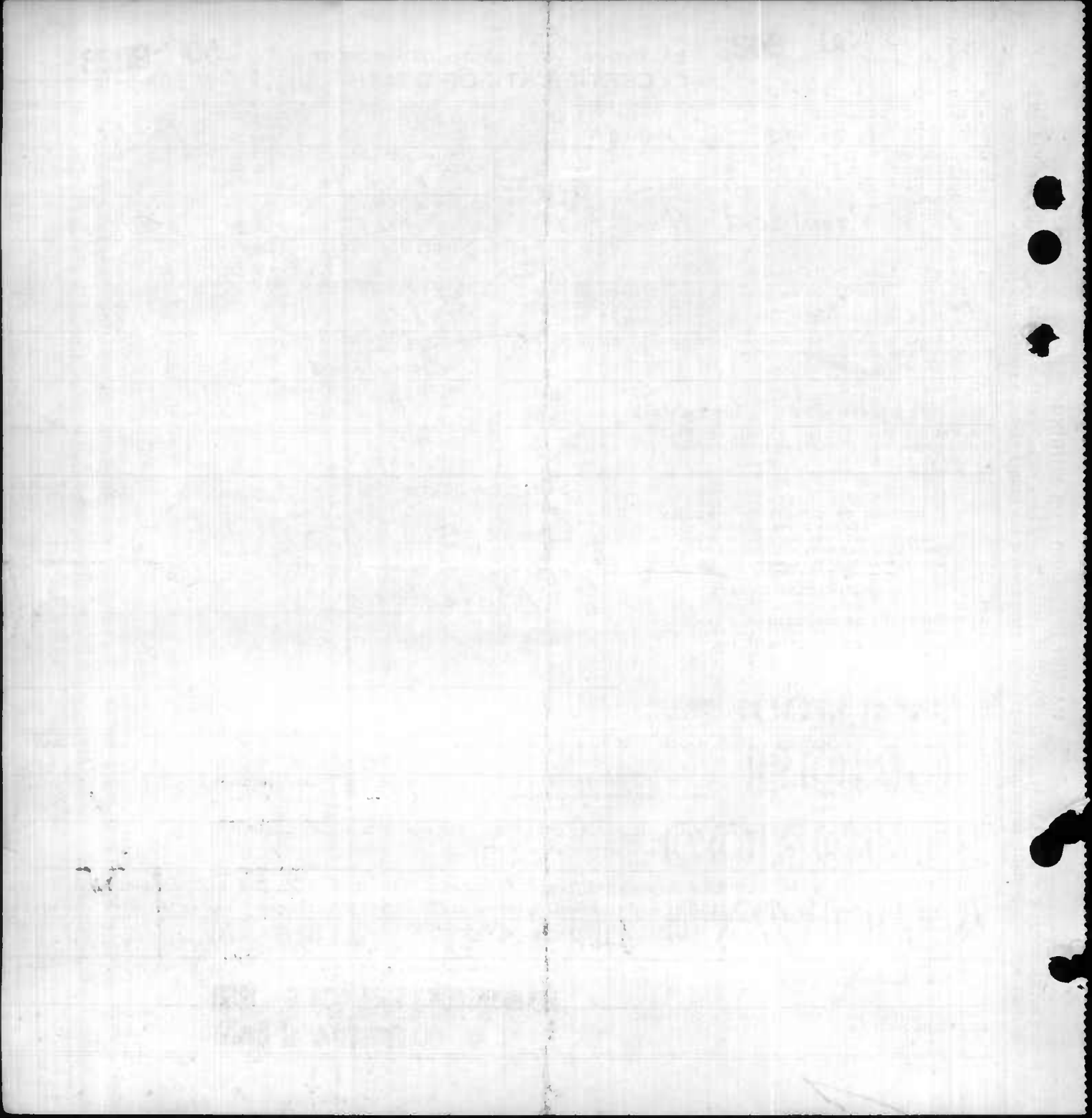
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JOHN HOPKINS MEDICAL SCHOOL OCT 6 1950

Commissioner of Health



D-650		50 9024		BALTIMORE CITY HEALTH DEPARTMENT		50 9024	
BIRTH NO. 50-22499				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Boy Down "B"				2. DATE OF DEATH 10-2-50			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ind.			
B. FULL NAME OF HOSPITAL OR INSTITUTION 38 Univ. Hsp.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt. 28-41			
c. Length of stay in Baltimore 3 Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) 4313 Elden Ave			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH 9-30-50	9. AGE (In years last birthday)	10 Under 1 Year Months: Days: 3	11 Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Abraham Down				14. MOTHER'S MAIDEN NAME Anne Lerin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Lerin Down		ADDRESS	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Prematurity			
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-2-1950, to 10-2-1950, that I last saw the deceased alive on 10-2-1950, and that death occurred at 8:00 A.M., from the causes and on the date stated above.							
23A. SIGNATURE [Signature]		23B. ADDRESS [Address]		23C. DATE SIGNED 11-2-50			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR OCT 22 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR [Signature]		ADDRESS	

1500

05

1500

05

CERTIFICATE OF DEATH



W-623
50 9025BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9025

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) MARGARET WRIGHT			2. DATE OF DEATH Oct 21, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland Balls Md			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE 1913 Eutaw place B. COUNTY Wilmington		
b. FULL NAME OF HOSPITAL OR INSTITUTION 1913 Eutaw place			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balls Md 14-01		
c. Length of stay in Baltimore 81			d. STREET ADDRESS (If rural, give location) 1913 Eutaw place		
5. SEX Female White	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug 10, 1869	9. AGE (In years, last birthday) 81	10. Under 1 Year Months: 2 Days: 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY		
11. FATHER'S NAME Unknown			12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			16. SOCIAL SECURITY NO. no		
17. INFORMANT Mr George A Wright Jr			ADDRESS 446 Linnard St		
18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION			INTERVAL BETWEEN ONSET AND DEATH ?		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic Heart Disease			?		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis			?		
19a. DATE OF OPERATION 0			19b. MAJOR FINDINGS OF OPERATION Malnutrition due to senile psychoses		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from JAN 1 , 1950 to Oct 21 , 1950, that I last saw the deceased alive on Oct 20 , 1950, and that death occurred at 6:30 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE Melvin N. Borden			23b. ADDRESS 2030 W. Fayette Street		23c. DATE SIGNED 10/22/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct 23, 1950		24c. NAME OF CEMETERY OR CREMATORY London Park Cemetery	
24d. LOCATION (City, town, or county) (State) Frederick Rd Balls Md		25. FUNERAL DIRECTOR David P. Martin			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE David P. Martin			
ADDRESS		ADDRESS 1902 Eutaw place			

E-24150 9026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 9026
Registered No.

BIRTH NO. 50-21650

1. NAME OF DECEASED
(Type or Print)

Baby Boy Eichelberger

2. DATE
OF
DEATH

Oct. 6/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

2 hrs.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

Oct. 6, 1950

9. AGE (In years
last birthday)If Under 1 Year
Months; DaysIf Under 24 Hours
Hours; Min.

2

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md/

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas

Robert Eichelberger

14. MOTHER'S MAIDEN NAME

Bertie Lee Ayers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Sinai Hospital

18. 757.3

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) DUE TO

Multiple congenital
anomalies including:

(B) DUE TO

1) absence of urethra
2) hypoplastic horseshoe kidney
3) imperforate anus
4) absence 2 lobes of lung

(C)

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL OCT 13 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

OCT 22 1950
VS 150

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9027

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50

9027

BIRTH NO. 50-20694

1. NAME OF DECEASED
(Type or Print)

Baby Bay Griffin

2. DATE
OF
DEATH

9-28-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md

B. COUNTY

Baltimore

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Lutheran Hosp of Md

C. CITY OR TOWN

Balto 14

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2317 Joppa Rd

5200

4. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9/28/50

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Donald William Griffin

14. MOTHER'S MAIDEN NAME

Edwina Wilma Lucerssen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Father

ADDRESS

Same

18. 750X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Anencephaly

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/28, 1950, to 9/28, 1950, that I last saw the
deceased alive on 9/28, 1950, and that death occurred at 12 midnight, from the causes and on the date stated above.

23A. SIGNATURE

Daniel Silverstein

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL OCT 5 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 22 1950

Commissioner of Health

Commissioner of Health

1958

06

UNITED STATES OF AMERICA

1958

06



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F-240

50 9028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9028

BIRTH NO. 50-21684

1. NAME OF DECEASED
(Type or Print)

Diane Louise Fogle

2. DATE
OF
DEATH

Oct 12 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland*

B. COUNTY *Balto*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Hospital for the Women of Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex-21

5200

D. STREET ADDRESS (If rural, give location)

27 Crofton Road

5. SEX

Female

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct 10 1950

9. AGE (In years last birthday)

10. Under 1 Year Months: Days: Hours: Min.

37

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Womans Hospital

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Glenn Fogle

14. MOTHER'S MAIDEN NAME

Mildred Arlene Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. *762.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Myocardial infarction, bilateral*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/10* 19*50*, to *10/12* 19*50*, that I last saw the deceased alive on *10/12* 19*50*, and that death occurred at *7⁰⁰* a.m., from the causes and on the date stated above.

23A. SIGNATURE

Jerome Kaufman

M. D.

23B. ADDRESS

Womans Hosp.

23C. DATE SIGNED

10/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

JOHN HOPKINS MEDICAL SCHOOL OCT 13 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 22 1950

William H. Williams, M.D.

Commissioner of Health

VS 150

161a

VALLEY
COUNCIL
OF
NATIONS

1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-2356 9029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9029

BIRTH NO. 50-21681

1. NAME OF DECEASED (Type or Print) BABY GIRL BAXTER - B			2. DATE OF DEATH October 11" 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
5. FULL NAME OF HOSPITAL OR INSTITUTION Hospital for Women of Maryland			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson - H 5300		
6. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1900 Glen Ridge Road.		
7. SEX Female	8. COLOR OR RACE W	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	10. DATE OF BIRTH October 11" 1950		11. AGE (In years last birthday) Months Days 13
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hospital in Women of Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Baxter			14. MOTHER'S MAIDEN NAME Marquinte Ruth Blackwood		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. **776X I**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **Immaturity**
DUE TO(B) **25 wk gestation, twin**
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Oct "**, 19**5**, to **Oct "**, 19**50**, that I last saw the deceased alive on **Oct "**, 19**50**, and that death occurred at **1:35A.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 22 1950

VS 150

JOHN HOPKINS MEDICAL SCHOOL

OCT 13 1950

Commissioner of Health

159.0

CSUB

ES22

100-100000-100000

100-100000-100000

B-236
50 9030BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 9030
Registered No.

BIRTH NO. 50-21680

1. NAME OF DECEASED (Type or Print) BABY BOY BAXTER "A"			2. DATE OF DEATH October 11 " 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION Hospital for Women of Maryland			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jowson - H -		
C. Length of stay in Baltimore 7 Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1900 Glen Ridge Road 5300		
5. SEX male	6. COLOR OR RACE w	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH October 11 " 1950	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Baxter			14. MOTHER'S MAIDEN NAME Marguerite Ruth Blackwood -		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		

18. 776X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Immaturity DUE TO (A) 25 wks. gestation, twin			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) 25 wks. gestation, twin DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 11, 1950 to Oct 11, 1950 , that I last saw the deceased alive on Oct 11, 1950 and that death occurred at 1:30 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE James N. McCosh		23B. ADDRESS 1014 St. Paul St.		23C. DATE SIGNED 10/12/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY JOHN HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		24E. DATE RECEIVED BY LOCAL REGISTRAR 10/12/50		24F. REGISTRAR'S SIGNATURE Commissioner of Health	
24G. DATE RECEIVED BY LOCAL REGISTRAR		24H. REGISTRAR'S SIGNATURE		24I. FUNERARY ADDRESS	

1000000000

1000000000

1000000000

L-140
50 9031BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9031
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anthony

Lippel

2. DATE
OF
DEATH

Oct. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

521 N. Madeira St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

7-03

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

521 N. Madeira St

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

2/28/89

9. AGE (In years
last birthday)

61

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Carpenter (const)

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

American

13. FATHER'S NAME

John Lippel

14. MOTHER'S MAIDEN NAME

Leona Sahlander

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Paul Lippel 2106 Bloom

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Disease

DUE TO

ANTECEDENT CAUSES

(B)

Hypertensive Cardio-
vascular Disease

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

2 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, J. M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☒23C. DATE SIGNED
Oct. 20, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct-23

24C. NAME OF CEMETERY OR CREMATORY

Most Holy Redeemer

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Kammer, J. M.D.

25. FUNERAL DIRECTOR

Ulrich Funeral Home

ADDRESS

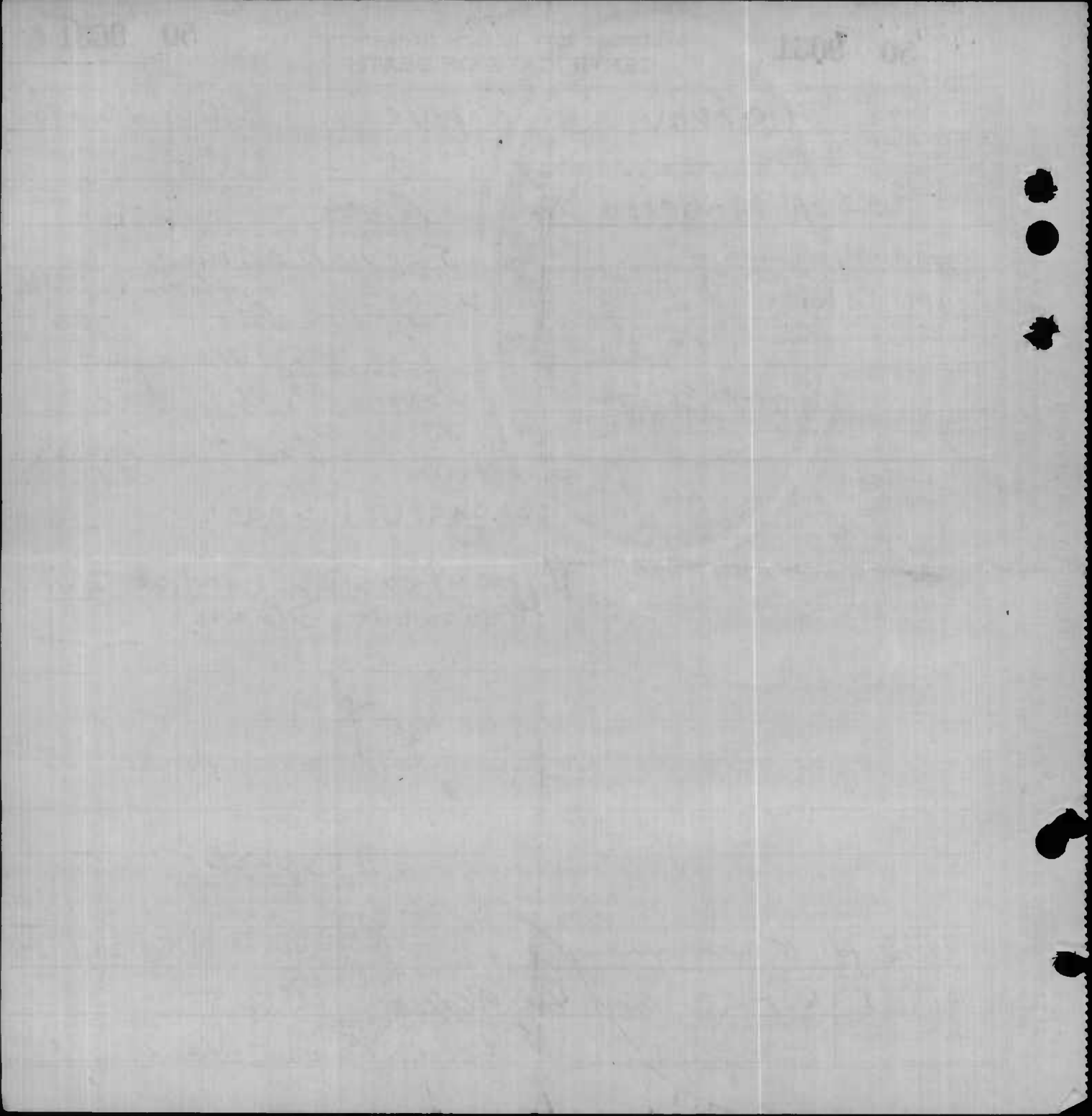
154 21950

51024

093

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9032

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Margaret Gleitsmann

2. DATE
OF
DEATH

Oct 20 / 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland *1700 Park Ave*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE *md* B. COUNTY *Balto*

b. FULL NAME OF HOSPITAL OR INSTITUTION *Wheeler Sanatorium*

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto *Burial 27-03*

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

d. STREET ADDRESS (If rural, give location)
2814 Rueckert Ave

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

Don't know

9. AGE (In years, last birthday)

80 yb

If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Gleitsmann

14. MOTHER'S MAIDEN NAME

Don't know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Edward J. Kuchn 2710 Rueckert Ave

18. *443X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebrovascular Heart Failure*

INTERVAL BETWEEN ONSET AND DEATH
1 month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Myocarditis
Hypertension*

Gradual

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May*, 1935, to *Oct 20*, 1950, that I last saw the deceased alive on *Oct 20*, 1950, and that death occurred at *10 A* m., from the causes and on the date stated above.

23A. SIGNATURE

H. H. Brady

23B. ADDRESS

1403 Park Ave

23C. DATE SIGNED

10-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct 23

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington William Brady

25. FUNERAL DIRECTOR

ADDRESS

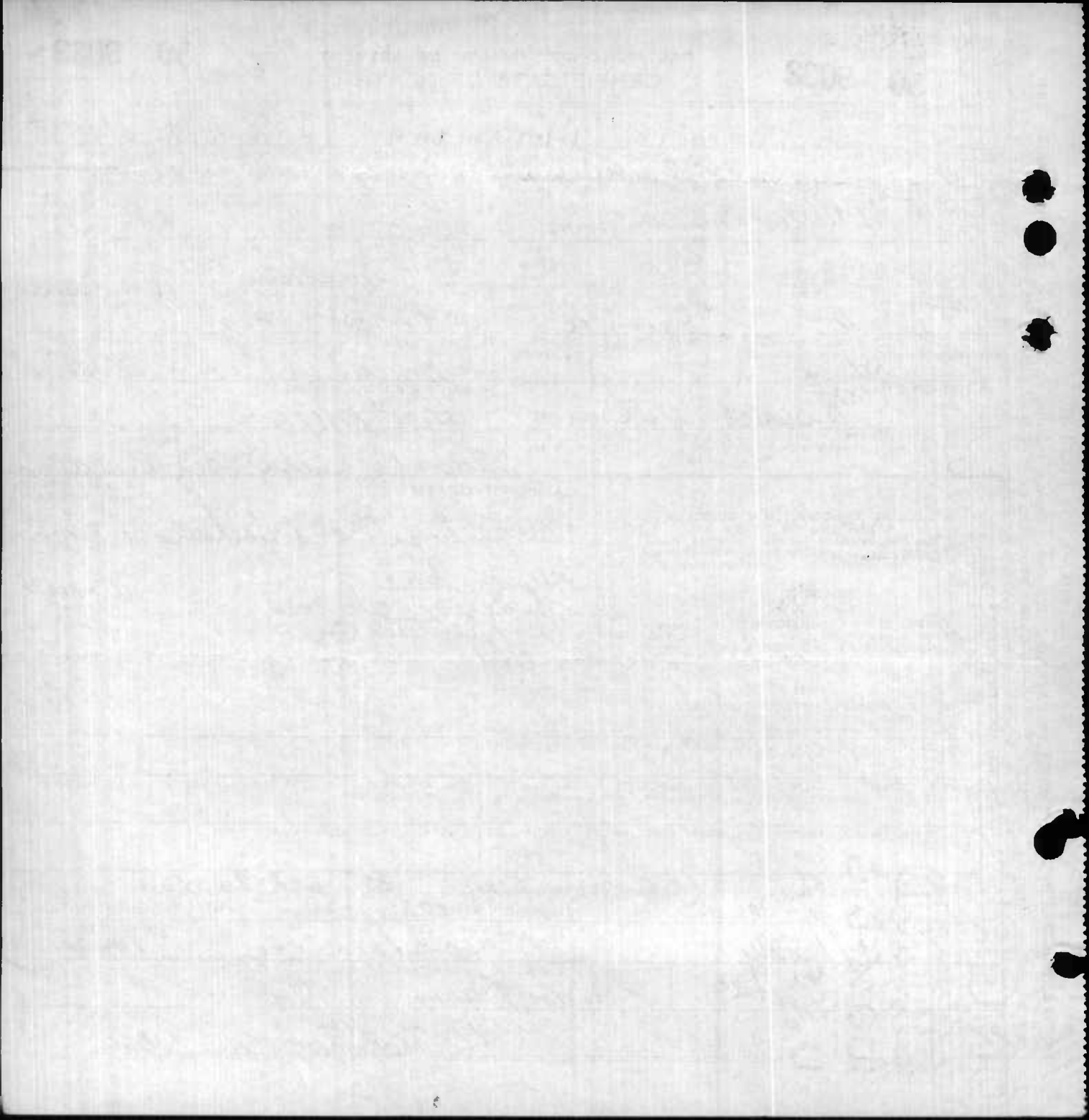
2003rd Funeral Home

OCT 22 1950

0932

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Essrig

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 9033

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHN HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MR. MARVIN ESSRIG, 1017 FRANKLAND ROAD.

18. 759.0

CAUSE OF DEATH

TAMPA, FLORIDA.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

JOHN HOPKINS HOSPITAL

22. I hereby certify that I attended the deceased from 10-18, 1950, to 10-21, 1950, that I last saw the deceased alive on 10-21, 1950, and that death occurred at 5:25 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

REMOVAL
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

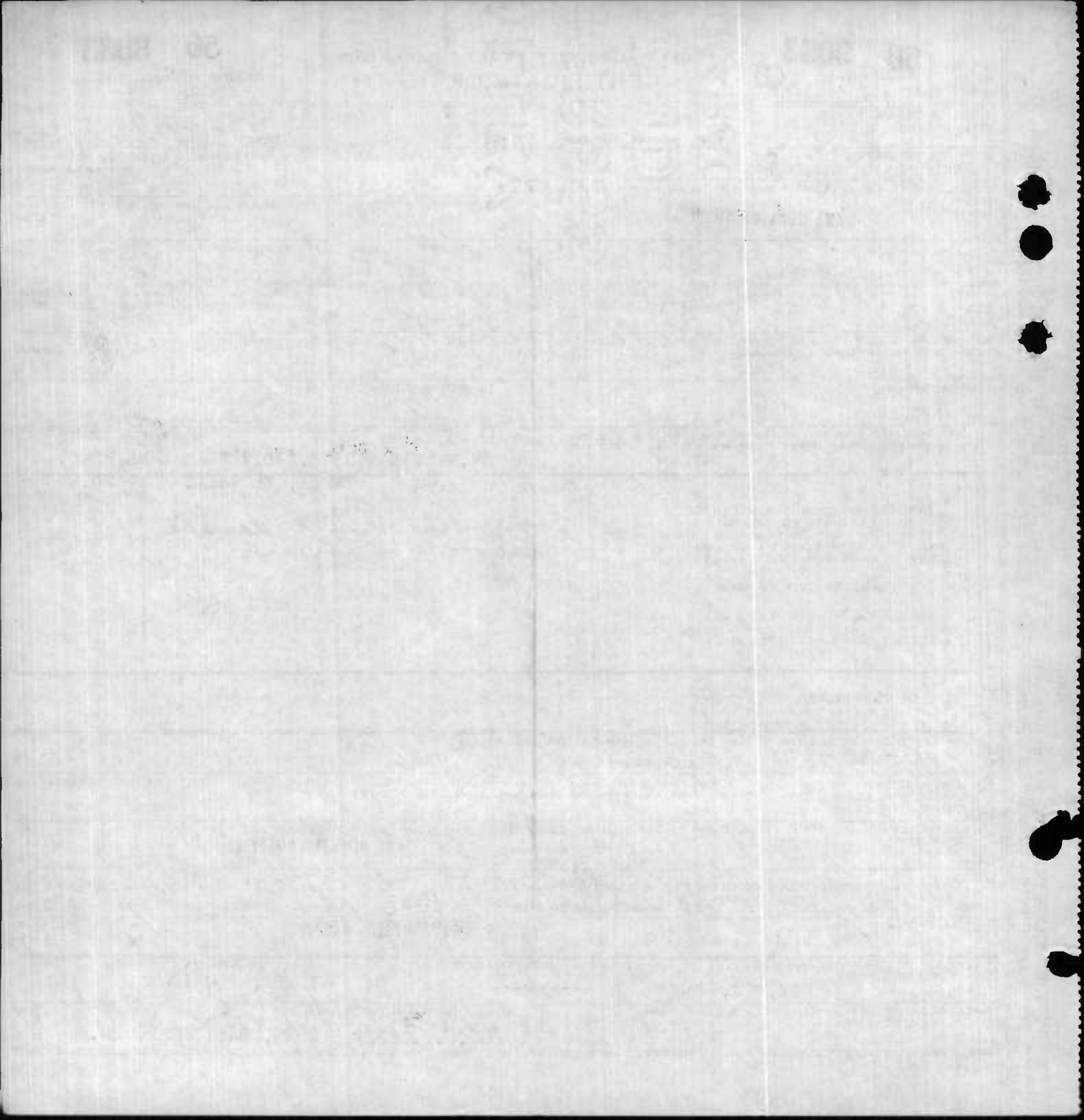
25. FUNERAL DIRECTOR

ADDRESS

W. J. TICKNER & SONS, BALTIMORE, MD.

OCT 22 1950

1572



P-36250 9034 *grave #8* BALTIMORE CITY HEALTH DEPARTMENT 50 9034
 CERTIFICATE OF DEATH Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print) OSWALD GEORGE WALDEMAR PEDERSEN			2. DATE OF DEATH Sept. 6, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____					
B. FULL NAME OF (If not in hospital or institution, give street address or location) Harbor - Key Highway & Stevenson St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) _____					
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) _____ 24-01					
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH			9. AGE (In years last birthday) 24-01 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		

18. E929.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Drowning DUE TO _____ (A) _____ ANTECEDENT CAUSES (B) _____ DUE TO _____ (C) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO _____ (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Harbor		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Found in harbor off the plant of the American Sugar Refinery, Key Highway & Stevenson	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Sept. 6, 1950 2:30 P. m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Found drowned	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input checked="" type="checkbox"/> .					
23A. SIGNATURE <i>Stanley K. Durlacher</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Sept. 22, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY PUBLIC CEMETERY OCT 13 1950	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	

1208 05

1208 05

RECEIVED

RECEIVED

RECEIVED

B-530 9035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 9035
Registered No.

BIRTH NO. 50-20229

1. NAME OF DECEASED
(Type or Print)

Baby Girl Bennett

2. DATE
OF
DEATH

Sept 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

33

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5800

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9-25-50

9. AGE (In years last birthday)

If Under 1 Year Months: Days: Hours: Min.

4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Mary Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 754.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

congenital heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER- LYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:20 PM., from the causes and on the date stated above.

23A. SIGNATURE

Rue W. Bass

M. O.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

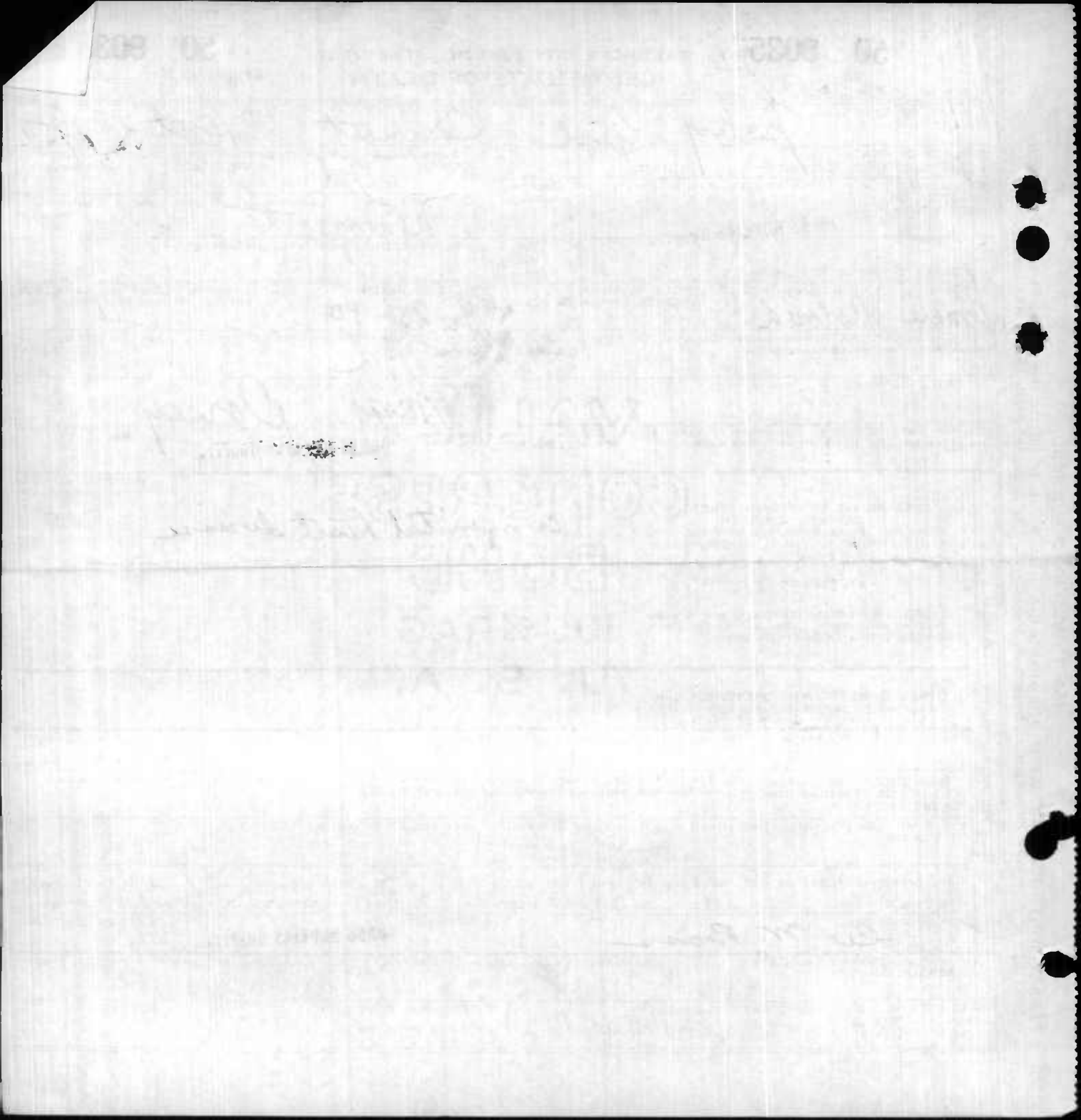
25. FUNERAL DIRECTOR

ADDRESS

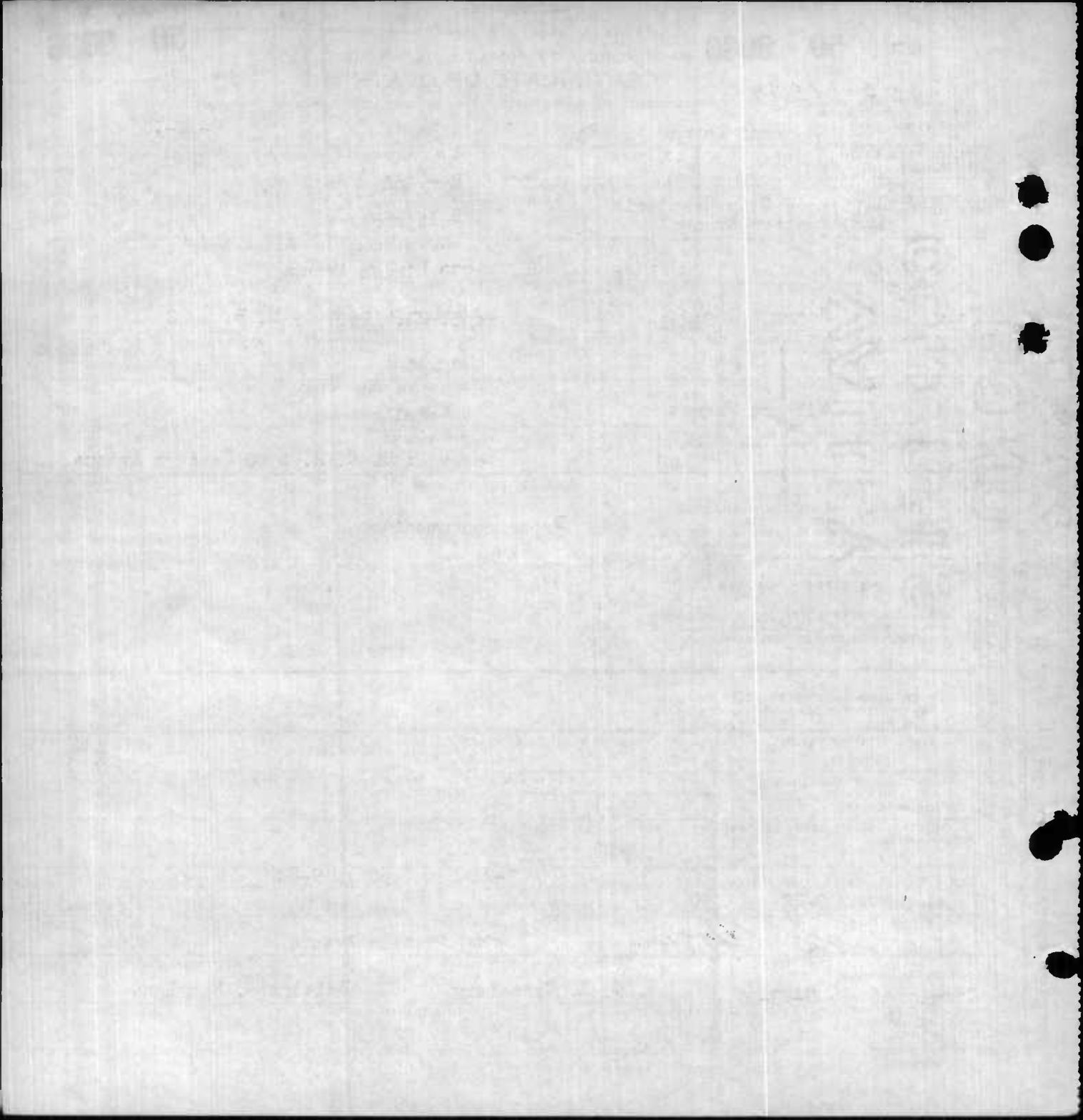
OCT 22 1950

Christington Williams, M.D.

9 0 3 3



T-520 50 9036		CERTIFICATE CORRECTED 10-27-50		50 9036	
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 50-14384				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Raymond Thomas			2. DATE OF DEATH 9-22-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-04		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 939 Linden Avenue		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 18, 1950 Sept. 22, 1950	9. AGE (In years last birthday) N.B.	If Under 1 Year Months: Days 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME Wilbert Thomas			14. MOTHER'S MAIDEN NAME Estelle Reese		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Records: B. C. H. 4940 Eastern Avenue		
18. 491 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Bronchopneumonia DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 9-22 1950, to 9-22 1950, that I last saw the deceased alive on 9-22 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.					
23A. SIGNATURE J. S. Corgan		23B. ADDRESS M. D. 4940 Eastern Avenue		23C. DATE SIGNED 9/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24B. DATE 9-23-50	24C. NAME OF CEMETERY OR CREMATORY B. C. H. Crematory	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
DATE RECEIVED BY LOCAL REGISTRAR OCT 22 1950	REGISTRAR'S SIGNATURE T. J. Williams	25. FUNERAL DIRECTOR 9 0 3 4		ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9037**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM COGAN			2. DATE OF DEATH OCTOBER 22, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NEW HAMPSHIRE B. COUNTY V-26		
B. FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) PORTSMOUTH		
C. Length of stay in Baltimore 3 WKS.			D. STREET ADDRESS (If rural, give location)		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JANUARY 13, 1864	9. AGE (In years last birthday) 86	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BREWERY INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (State or foreign country) NEW HAMPSHIRE		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN COGAN			14. MOTHER'S MAIDEN NAME ELLEN ALLEN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT ADDRESS MRS. ANNE T. LEARY, 1020 CAMERON RD., BALTIMORE		
18. 540.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Intestinal Obstruction DUE TO Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH 2+ wks. 5+ yrs. 5+ yrs.		
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from OCTOBER 14, 1950 , to OCTOBER 22, 1950 , that I last saw the deceased alive on OCTOBER 22, 1950 , and that death occurred at 5:30 a.m. , from the causes and on the date stated above.					
23A. SIGNATURE Wallace J. Buttchick		23B. ADDRESS Union Memorial Hospital		23C. DATE SIGNED 22 Oct 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/25/50		24C. NAME OF CEMETERY OR CREMATORY Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Portsmouth Mass		25. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	

OCT 22 1950

117a

1. The first part of the report is a general
description of the area. It is a large
area of land, mostly flat, with some
low hills in the north. The climate is
warm and humid. The population is
large and the economy is based on
agriculture. The main crops are rice
and sugarcane. There are also some
small industries. The government is
trying to improve the infrastructure
and the economy. There are some
problems, but the future is bright.

D-120
50 9038BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9038
Registered No.

BIRTH NO. 50-20400

1. NAME OF DECEASED (Type or Print) <i>Keith Zachary Davis</i>			2. DATE OF DEATH <i>9-27-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 16-04</i>		
c. Length of stay in Baltimore <i>14 hrs. 58 min.</i>			D. STREET ADDRESS (If rural, give location) <i>815 N. Appleton St</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>9-27-50</i>	9. AGE (In years last birthday)	10. Under 1 Year Months Days <i>14 58</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, md.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Bertym Davis</i>			14. MOTHER'S MAIDEN NAME <i>Evelyn Davis</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Evelyn Davis 815 N. Appleton</i>		

18. <i>762.5</i>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Prematurity (116. 14 gms.)</i>	
DUE TO		(B) <i>Congenital atelectasis</i>	
DUE TO		(C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9/27, 1950</i> , to <i>9/27, 1950</i> , that I last saw the deceased alive on <i>9/27, 1950</i> and that death occurred at <i>9 p. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>W. B. Bulley</i>		23B. ADDRESS <i>Provident Hospital</i>		23C. DATE SIGNED <i>9/28/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>W. B. Bulley</i>		25. FUNERAL ADDRESS	

JOHN HOPKINS MEDICAL SCHOOL
OCT 6 1950
Commissioner of Health

1881

Sept 17 1893

C-453
50 9039BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9039
Registered No.

BIRTH NO. 50-16729

1. NAME OF DECEASED
(Type or Print)

Infant

Clinton I

2. DATE
OF
DEATH

9-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

39 Provident Hospital

C. Length of stay in Baltimore

24

Yrs.
Mos.
(Day)

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8-10-50

9. AGE (In years
last birthday)10 Under 1 Year
Months: Days

24

11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of work life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

Willie Clinton

14. MOTHER'S MAIDEN NAME

Lucille Singleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Birth Certificate

18. 764.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Diarrhea

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

5 days

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 8/10, 1950, to 9/2, 1950, that I last saw the
deceased alive on 9/2, 1950, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

M. B. Butler

M. D.

23B. ADDRESS

2033 E. Mt. Pleasant

23C. DATE SIGNED

9/7/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

JOHN HOPKINS MEDICAL SCHOOL SEP 22 1950
Commissioner of Health

ADDRESS

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000

1000

1000

1000

1000

1000

1000

1000

1000

H-545
50 9040BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

X 50 9040

BIRTH NO. 50-20065

1. NAME OF DECEASED
(Type or Print)

Baby Heinlein

2. DATE
OF
DEATH

9/17/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hosp.

4. USUAL RESIDENCE (Where deceased lived If institution: residence
before admission)

A. STATE

Md.

B. COUNTY

Baltimore

C. CITY OR TOWN

Brooklyn Md.

D. STREET ADDRESS (If rural, give location)

325 Riverman Rd.

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9/17/50

9. AGE (In years
last birthday)10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min

15

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

newborn

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George H. Heinlein

14. MOTHER'S MAIDEN NAME

Sylvia Rosalie Frye

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

mother

ADDRESS

same

18. 761.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH13 min
after birth

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/17, 1950, to 9/17, 1950, that I last saw the
deceased alive on 7/17, 1950, and that death occurred at 3:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

G. H. Heinlein

M. D.

23B. ADDRESS

Univ. Hospital

23C. DATE SIGNED

9/17/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JOHN HOPKINS MEDICAL SCHOOL SEP 22 1950

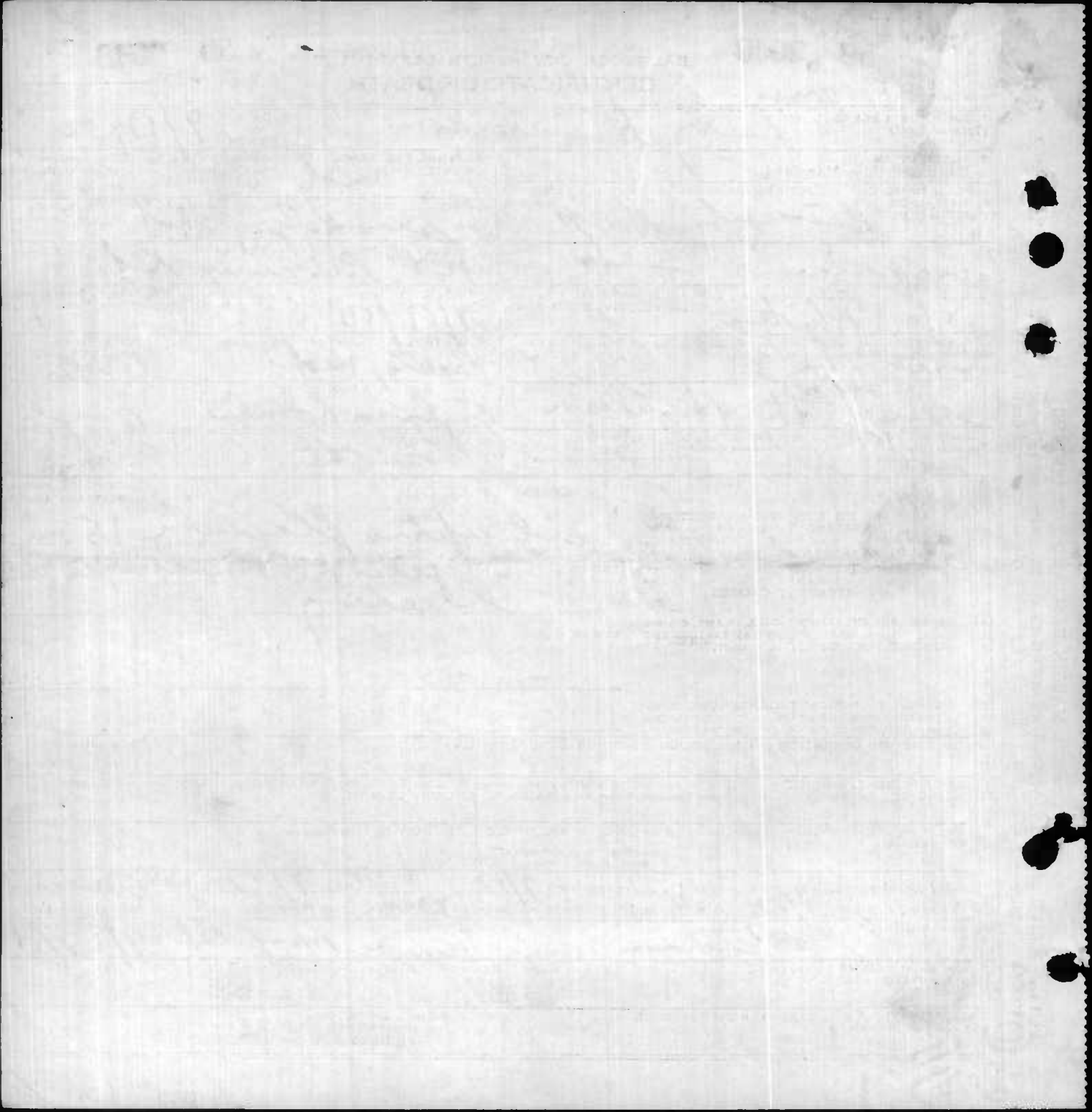
Commissioner of Health

VS 150

160c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



M-266
50 9041BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9041

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Fred M. Crany

2. DATE
OF
DEATH

October 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

Yrs.
Mos.
Days

c. Length of stay in Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

912 N. Eden St.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

10-2-1900

9. AGE (in years
last birthday)

50

If Under 1 Year
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

UMPIRE

10B. KIND OF BUSINESS OR
INDUSTRY

BASEBALL LEAGUE

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John M. Crany

14. MOTHER'S MAIDEN NAME

Bessie Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

289.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Uremia

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

4 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Primary amyloid disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Generalized arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-17, 1950, to 10-19, 1950, that I last saw the
deceased alive on 10-19, 1950, and that death occurred at 8 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Victor A. McKusick

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10/20/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/24/50

24C. NAME OF CEMETERY OR CREMATORY

Rest Vale Cem. Chicago, Ill.

24D. LOCATION (City, town, or county)

(State)

REGISTRAR'S SIGNATURE

W. H. P. G. P. O.

25. FUNERAL DIRECTOR

Charles R. Lew- 802 Mad. Rd.

ADDRESS

DATE RECEIVED BY
LOCAL REGISTRAROCT 22 1950
VS 150

0918M

097.0

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]



B-652
REA-116545

50 9042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9042

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Peter Burns

2. DATE
OF
DEATH

October 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTION location)Baltimore City Hospitals
4940 Eastern AvenueC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1211 Battery Ave. 1112 Battery Avenue

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 3, 1861

9. AGE (In years
last birthday)

89

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Maker of Tin Cans

10B. KIND OF BUSINESS OR
INDUSTRY

Tin Factory

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Lucky Burns

(D)

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

Over 2Yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-13, 1948, to 10-18, 1950 that I last saw the
deceased alive on 10-18, 1950 and that death occurred at 3A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4940 Eastern Avenue

10-20-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Oct. 23, 1950

Holy Cross

A.A.Co. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 22 1950

Flyn & Fleming

1426 Light St.

VS 150

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 3015

STATE OF NEW YORK

CERTIFICATE OF DEATH

50 3015



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Allen, Marie (Marie Allen)

2. DATE

OF DEATH Oct. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

422 E. Clement St.

c. Length of stay in Baltimore Life

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct. 29

9. AGE (In years last birthday)

56

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hwfe.

10B. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Balto.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John N. Hook Sr.

14. MOTHER'S MAIDEN NAME

Josephine Landers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Julian E. Allen 422 E. Clement St.

18. 580X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Acute yellow atrophy
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Liver
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 9, 1950, to Oct. 19, 1950 that I last saw the deceased alive on Oct. 19, 1950, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct. 23, 1950

Cathedral

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 22 1950

Thurston Williams

Flynn & Fleming 1426 Light St.

30 0013

30 0013

RECEIVED
CENTRAL INTELLIGENCE AGENCY
WASHINGTON, D.C. 20505



50 9044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9044

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Albert Deneke

2. DATE
OF
DEATH

October 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

14 S. Payson Street

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

20-03

D. STREET ADDRESS (If rural, give location)

14 S. Payson Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct. 16, 1876

9. AGE (in years
last birthday)

74 years

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Ret. Car - Repairman

10B. KIND OF BUSINESS OR
INDUSTRY

B. & O. R. R.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Deneke

14. MOTHER'S MAIDEN NAME

Mollie

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lillian P. Deneke, 14 S. Payson Street

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Carcinoma Prostate Gland

DUE TO

1945

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Bronchogenic Carcinoma
Bilateral

DUE TO

1949

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

20. AUTOPSY?

YES ☐NO ☐

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐

WORK

NOT WHILE ☐

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 10, 1935, to Oct. 20, 1950, that I last saw the
deceased alive on Oct 19, 1950, and that death occurred at 4 P. m., from the causes and on the date stated above.

23A. SIGNATURE

George E. Shannon

M. D.

23B. ADDRESS

820 Medical Arts Bldg

23C. DATE SIGNED

10/20/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

10/23/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

St. M. Book, Inc. 1217 St. Paul Street

VS 150

553.50

0516

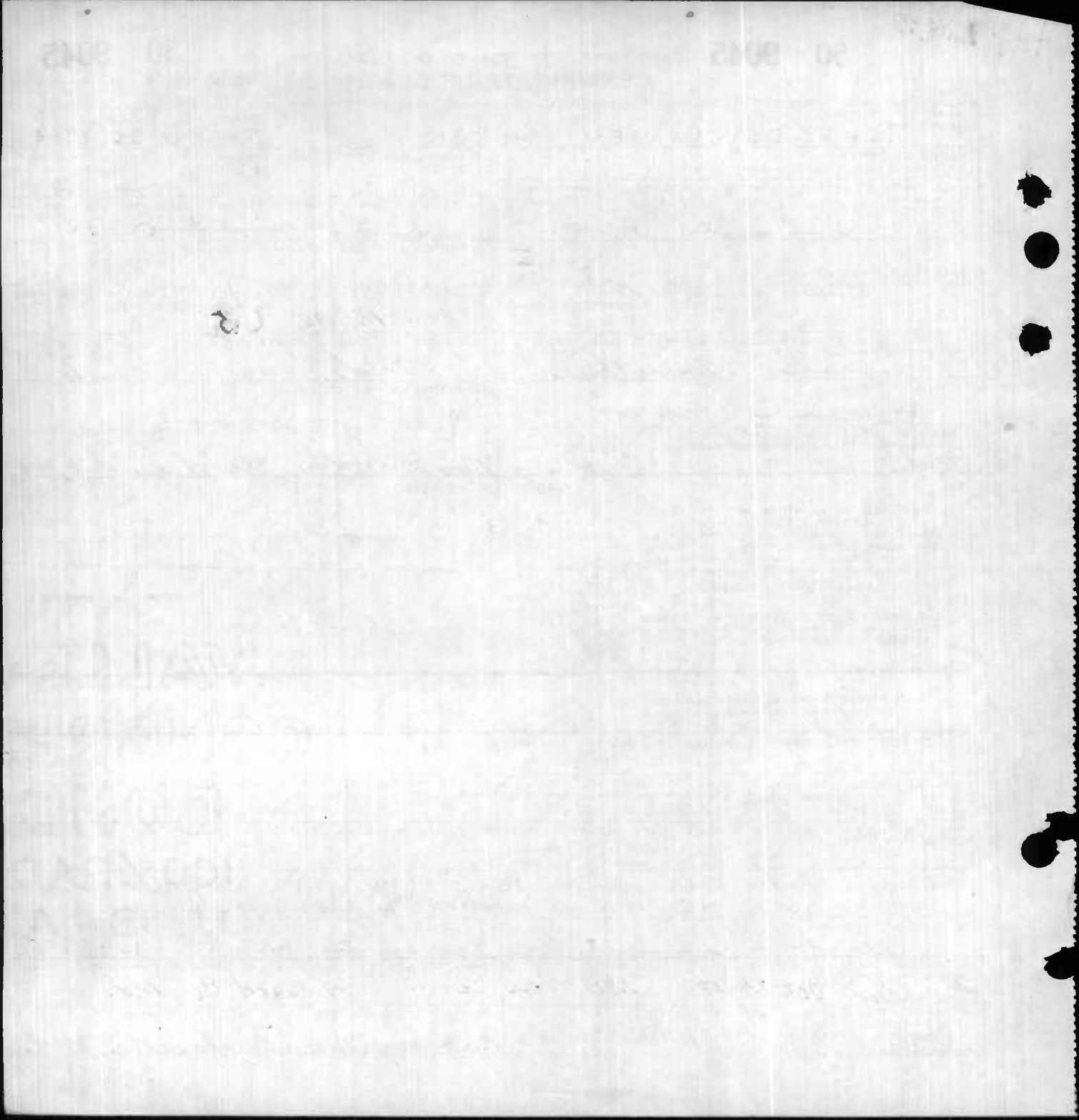
bronchogenic - originating in a bronchus
query :-

Assessing primary site of cancer to be
lung, as dates on interval between onset
and death incorrect?

See Document File 50 - 9044

10-31-50

ES



B. 450

50 9046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9046

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>Joshua Jacob Bellin</u>		2. DATE OF DEATH <u>10-20-50.</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St Josephs Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>27-02</u>	
c. Length of stay in Baltimore <u>60</u> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <u>2908 Gaydon Av.</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 23 1878</u> 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner & Greta Kor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob Bellin</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Augusta Bellin</u>		ADDRESS	

18. <u>151X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>Massive hemorrhage due to adenoma carcinoma of stomach.</u> (B) _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION <u>Sept. 21, 1950.</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of the Cardia</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9-17</u> , 19 <u>50</u> , to <u>10-20</u> , 19 <u>50</u> that I last saw the deceased alive on <u>10-20</u> , 19 <u>50</u> , and that death occurred at <u>11:45 p.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>B. J. J. J.</u>		23B. ADDRESS <u>1400 N. Caroline St.</u>		23C. DATE SIGNED <u>10-20-50.</u>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-23-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>Burial</u>		REGISTRAR'S SIGNATURE <u>William J. J.</u>		25. FUNERAL DIRECTOR <u>Wm. Carl J.</u>		ADDRESS <u>1217 St Paul St</u>	

OCT 23 1950

82010

0466

MARGIN RESERVED FOR BINDING
PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

W. W. Wadlow,

10/23-50

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9047

Registered No. _____

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <i>James Crapton Thomas</i>		2. DATE OF DEATH <i>Oct. 20, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2034 Ruxton Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-04</i>			
c. Length of stay in Baltimore <i>35 years</i>		D. STREET ADDRESS (If rural, give location) <i>2034 Ruxton Ave</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 22, 1909</i>	9. AGE (in years last birthday) <i>40</i>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bar Tender</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Lavern</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Elmer Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Myrtle V. Hill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>216-03-8855</i>		17. INFORMANT <i>Mrs. Celestine Thomas</i>	
18. <i>002X</i>		CAUSE OF DEATH		ADDRESS <i>2034 Ruxton Ave.</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <i>Advanced pulmonary tbc</i> DUE TO			
ANTECEDENT CAUSES		(B) _____ DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) _____ DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 2, 1950</i> , to <i>Oct 20, 1950</i> , that I last saw the deceased alive on <i>10-20-1950</i> and that death occurred at <i>1:30 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Geo. H. Tinsley</i>		23B. ADDRESS <i>1723 Druid Hill Ave</i>		23C. DATE SIGNED <i>10-21-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct. 23, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore W. Md.</i>		24E. REGISTRAR'S SIGNATURE <i>Wm. H. Williams</i>		24F. FUNERAL DIRECTOR <i>Hallard Funeral Home</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 23 1950</i>		25. ADDRESS <i>2034 Ruxton Ave.</i>			

VS 150

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013 L

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[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

50 9048

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9048

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MAUDE T. LUDWIG.

2. DATE
OF
DEATH

Oct. 19-1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

146-5. Hilton St.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, 20-07

D. STREET ADDRESS (If rural, give location)

146-5. Hilton St.

c. Length of stay in Baltimore

Life.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Married.

8. DATE OF BIRTH

Oct. 20-1883

9. AGE (In years last birthday)

66 yrs.

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home.

11. BIRTHPLACE (State or foreign country)

Baltimore - Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Callahan.

14. MOTHER'S MAIDEN NAME

Catherine Schley.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no.

(If yes, give war or dates of service)
none

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mrs. Loretta Luemig-146-5. Hilton St.

ADDRESS

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

1 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive Heart Disease

DUE TO

1 mo.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

2 yr

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1947 to Oct 19, 1950, that I last saw the deceased alive on Oct 19, 1950 and that death occurred at 7:32 m., from the causes and on the date stated above.

23A. SIGNATURE

J. M. Callahan

23B. ADDRESS

3321 Fredrick Ave

23C. DATE SIGNED

10-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial.

24B. DATE

Oct. 23/1950

24C. NAME OF CEMETERY OR CREMATORY

London Park Cemetery.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

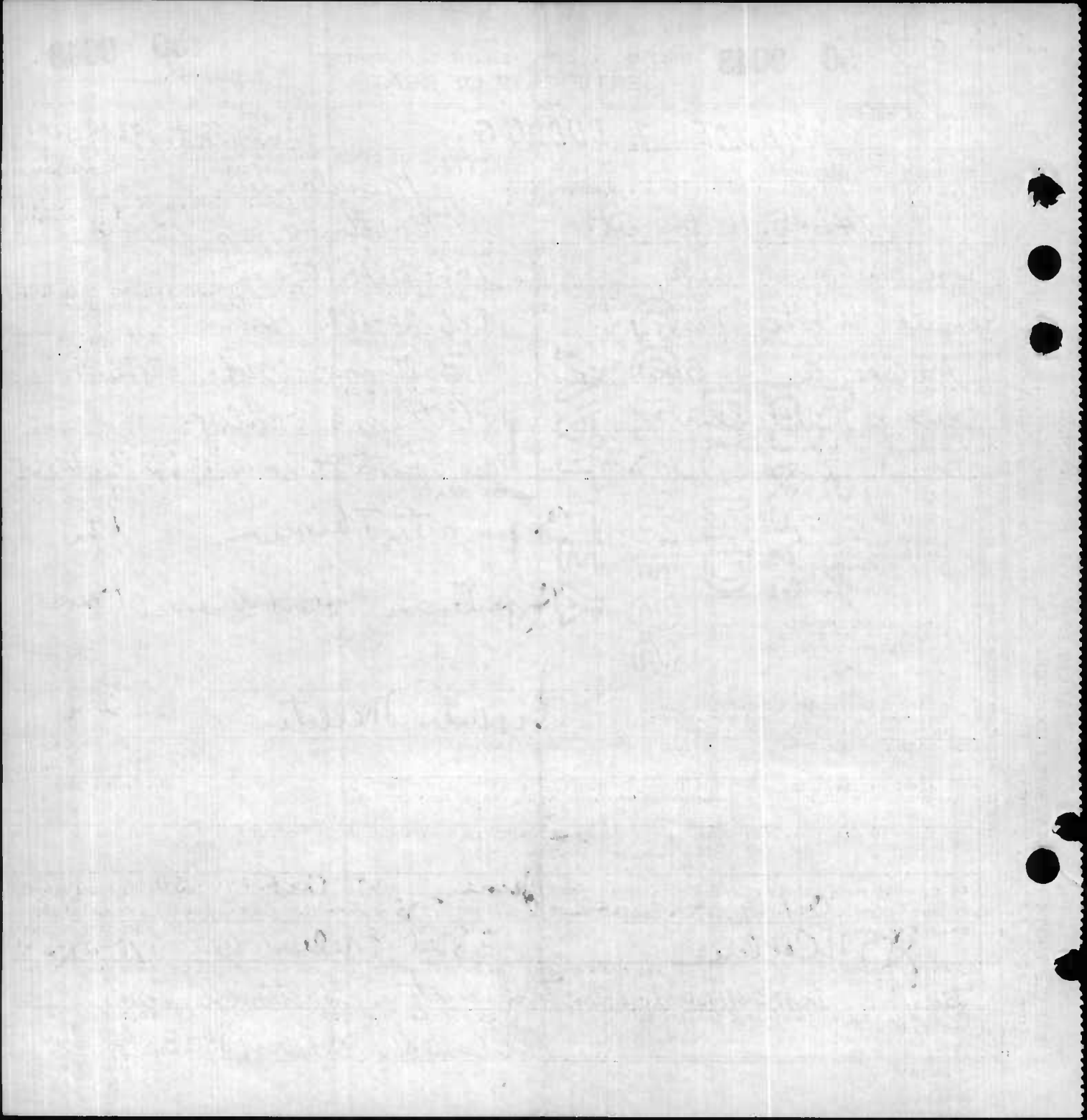
REGISTRAR'S SIGNATURE

J. M. Callahan

25. FUNERAL DIRECTOR

Charles J. Schwalb, 3512 Fredrick Ave.

ADDRESS



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

252 50 9049 BALTIMORE CITY HEALTH DEPARTMENT
 50 9049

CERTIFICATE OF DEATH

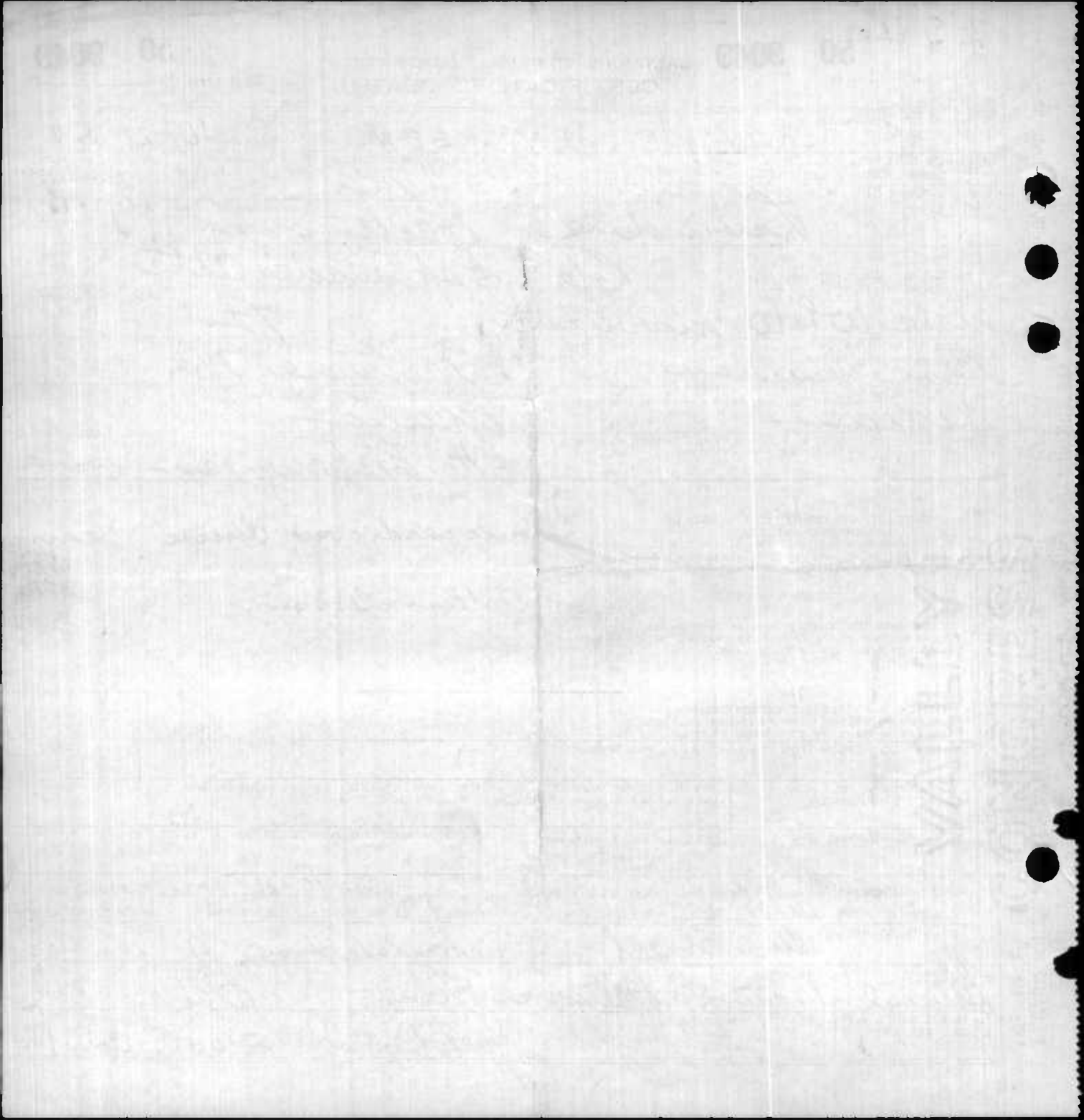
Registered No. _____

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		IRVIN EICHENGREEN		10-21-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Levindale		C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore			
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) Esplanade Apts			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 7-2	9. AGE (in years, months, days) 72	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work, showing most of working life, even if retired) Shoe Salesman		10B. KIND OF BUSINESS OR INDUSTRY (R)		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME William		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Anelia	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Chronic cardiovascular disease DUE TO (B) Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH years	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-19 1950, to 10-21 1950, that I last saw the deceased alive on 10-21 1950, and that death occurred at 9:30 p. m., from the causes and on the date stated above.					
23A. SIGNATURE Henry Nagel		23B. ADDRESS Levindale Home		23C. DATE SIGNED 10-21-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-23-50		24C. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25. FUNERAL DIRECTOR Jack Lewis		ADDRESS 2100 Canton Rd	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE Huntington Williams			

VS 150

490 LF

093 d



50 9050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9050
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 570 Comb al.
- (c) Hospital or institution: 600-699
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State md (b) County
- (c) City or town Balto 22-01
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 570 Comb al.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mabel Brown Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Daniel Carroll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-7-18998. AGE: Years 51 Months 7 Days 14 If less than one day hr. min.9. Birthplace Va
(Town, county, and state)10. Usual Occupation at home

11. Industry or business

12. Name Henry Brown13. Birthplace Va14. Maiden Name Eva Briggsby15 Birthplace Va16 (a) Informant Isabella Hill(b) Address 8 W York St17 (a) Burial (b) Date thereof Oct 24-50
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory mt. Calvary
Location a a. c. md18 (a) Funeral director James A. Stages(b) Address 638 N. Gilman St19 (a) Oct 23 1950 (b) William M. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1950, at - M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1950 to Oct 21 1950 and that I last saw him alive on Oct 19 1950

Immediate cause of death

Pulmonary Interstitial

Duration

6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
- (e) Means of injury

23. Signature

W. P. Johnson M. D.
Address 403 N. York St Date signed 10/21-50

PHYSICIAN

Underline the cause to which death should be charged statistically.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

50 9051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9051

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SARAH COLLINS		2. DATE OF DEATH 20 Oct 50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-03	
B. FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Hosp. 27 N. Carey St		D. STREET ADDRESS (If rural, give location) 2402 Francis St.		Yrs. Mos. Days	
c. Length of stay in Baltimore		5. SEX Female		6. COLOR OR RACE Colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Dec. 2, 1867		9. AGE (In years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard Owens		14. MOTHER'S MAIDEN NAME Lucie Bowen		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Bernice Evans Francis St.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis DUE TO marked arteriosclerotic (b) Cardio-vascular disease DUE TO with senility. (c) Malnutrition.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 14 Oct , 19 50 , to 20 Oct , 19 50 , that I last saw the deceased alive on 20 Oct , 19 50 , and that death occurred at 11 A m., from the causes and on the date stated above.					
23A. SIGNATURE Emil H. Henning		23B. ADDRESS 601 W. Main Way		23C. DATE SIGNED 20 Oct 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-23-50		24C. NAME OF CEMETERY OR CREMATORY W. B. Boddie	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25. FUNERAL DIRECTOR W. B. Boddie		ADDRESS 378	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE W. B. Boddie		25. FUNERAL DIRECTOR W. B. Boddie	

CLUB OF THE CITY OF NEW YORK

NEW YORK, N. Y. 10001

10001

10001

REA-140747

50 9052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 9052

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna Lewis			2. DATE OF DEATH Oct. 19, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Life Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1522 Harlem Avenue		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 11, 1872	9. AGE (In years last birthday) 78	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10B. KIND OF BUSINESS OR INDUSTRY Private		
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Abraham Marshal (Marshall) (D)			14. MOTHER'S MAIDEN NAME Bitsy Boulden (Betsy) (D)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Records: B. C. H. 4940 Eastern Avenue			ADDRESS		

18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia Rt. (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease with Myocardial		2 Mos.

19A. DATE OF OPERATION 10-19-50		19B. MAJOR FINDINGS OF OPERATION Infarction		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-17 , 19 50 to 10-19 , 19 50 , that I last saw the deceased alive on 10-19 , 19 50 and that death occurred at 8:35 P.m. , from the causes and on the date stated above.					
23A. SIGNATURE A. B. Crogen		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 10-21-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-24-50		24C. NAME OF CEMETERY OR CREMATORY St. Ambrose Cem	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25. FUNERAL DIRECTOR 50 Biddle Address 578			
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE Huntington Williams			

9-10-19

10

STATE OF NEW YORK

CERTIFICATE OF DEATH

10-10-19

10-10-19

X

10

10

10

10

10

10

10

10

10

10



50 9053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9053
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES FRANCIS BROWN

2. DATE
OF
DEATH

10-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 33rd Calvert Sts.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 13-01

D. STREET ADDRESS (If rural, give location)

Weyman Park Dr. 13-01

c. Length of stay in Baltimore

67 years

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE/MARRIED.

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8-5-1883

9. AGE (in years last birthday)

67

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Dealer

10B. KIND OF BUSINESS OR INDUSTRY

Coal (W)

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

USA

13. FATHER'S NAME

Charles H. Brown

14. MOTHER'S MAIDEN NAME

Elizabeth Bullock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Jane S. Brown (wife)

ADDRESS

Weyman Park Dr.

18. 416X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-19, 1950, to 10-20, 1950, that I last saw the deceased alive on 10-20, 1950, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Wallace R. Buttice, D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

20 Oct 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct-23-1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

Stewart & Mawer Co., 108-W-North Ave.

25. FUNERAL DIRECTOR

Stewart & Mawer Co., 108-W-North Ave.

ADDRESS

City #1. 0956

VS 150

29068

[Faint, illegible handwriting throughout the page]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months Days
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Husband ADDRESS
Charles E. McKeldin 1143 Carroll St

18. 061x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tetanus due to ingrown toenail

3 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Circulatory Collapse

Terminated

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-17, 1950, to 10-21, 1950, that I last saw the deceased alive on 10-21, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOT A MEDICAL EXAMINER'S CASE

M.D.

CHIEF OR ASS'T. MEDICAL EXAMINER

Not a Medical Examiner Case,

Stanley H. Durlacher, M.D.,
Asst. Med. Exam

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-162

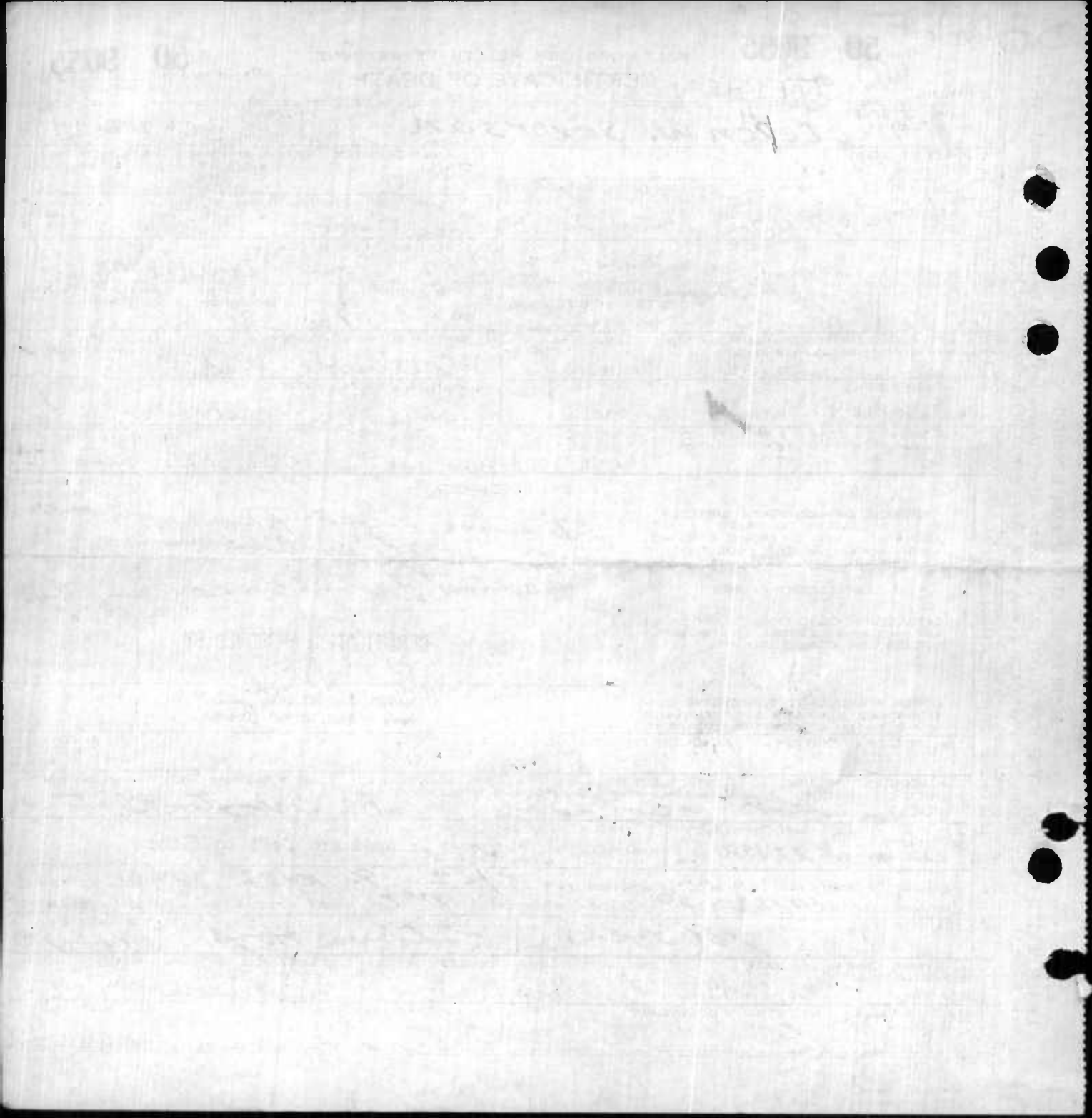
50 9055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 9055

BIRTH NO.		STEPHEN	
1. NAME OF DECEASED (Type or Print)		Stephen W. Severson	
3. PLACE OF DEATH: A. Baltimore City, Maryland		2. DATE OF DEATH Oct 22, 1950	
B. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore	
C. Length of stay in Baltimore Life		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Catonsville	
D. STREET ADDRESS (If rural, give location) 602 Orpington Road		5. SEX Male	
6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	
8. DATE OF BIRTH July 31, 1870		9. AGE (In years last birthday) 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Jewelry Salesman		10B. KIND OF BUSINESS OR INDUSTRY Jewelry	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? ✓	
13. FATHER'S NAME Stephen W. Severson		14. MOTHER'S MAIDEN NAME Margaret Meredith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 212-16-6008	
17. INFORMANT Evalynn M. Severson		ADDRESS 602 Orpington Rd.	
18. E903.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Fracture, Left Femur - 2 mon. Generalized arteriosclerosis Terminal Bronchopneumonia - 4 days		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY William H. Smith M.D. CHIEF OR ASST. MEDICAL EXAMINER.	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) about home	
21C. WHERE DID INJURY OCCUR? 602 Orpington Rd, Catonsville		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 22 1950	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Tripped and fell to floor	
22. I hereby certify that I attended the deceased from 8/22, 1950, to 10/22, 1950, that I last saw the deceased alive on 10/22, 1950, and that death occurred at 3:20 P.M., from the causes and on the date stated above.			
23A. SIGNATURE M. Severson		23B. ADDRESS Lutheran Hosp	
23C. DATE SIGNED 10/22/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 25-1950	
24C. NAME OF CEMETERY OR CREMATORY Landon Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE W. H. Smith	
25. FUNERAL DIRECTOR Mr. John P. Seuffer		ADDRESS 5311 Edmondson Ave	



CERTIFICATE CORRECTED 11-6-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9056
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

STANSBURY MORRIS WILSON

2. DATE
OF
DEATH

21 Oct 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD. B. COUNTY BALT.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE #10 27-13

D. STREET ADDRESS (If rural, give location)

206 LONGWOOD ROAD

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

13 Nov. 1889

9. AGE (in years last birthday)

60

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TECHNICAL DIRECTOR

10B. KIND OF BUSINESS OR INDUSTRY

Chemical (M)

11. BIRTHPLACE (State or foreign country)

ILL.

12. CITIZEN OF WHAT COUNTRY?

AMERICAN

13. FATHER'S NAME

WILLIAM H. WILSON

14. MOTHER'S MAIDEN NAME

MAUDE OLIVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

PATIENT

ADDRESS

18. 587.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Acute Pancreatitis
Mesenteric Thrombosis

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.Old tuberculous pericarditis
and left Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

10-19-50

19B. MAJOR FINDINGS OF OPERATION

No abnormal finding

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-19, 1950 to 10-21, 1950, that I last saw the deceased alive on 10-21, 1950, and that death occurred at 8:20 a.m., from the causes and on the date stated above.

23A. SIGNATURE

F. Hanson Watt

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

10-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/23/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Dickert & Sons - Balto Md.

ADDRESS

NO 3088

NO 3088

21 Oct 1950

Stacy M. Mann

MO

Partnership

see below

1944-1950

Inc.

Amesbury

Mass. State

PATENT

William H. Wilson

[Faint, mostly illegible text follows, appearing to be a continuation of a document or a series of notes.]

30 1937

30 1937

RECEIVED

CONFIDENTIAL

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9058
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELVA M. FORNCROOK

2. DATE

OF DEATH October 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Kansas

B. COUNTY Clayton

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Found in harbor at the foot of

Cromwell Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Kansas

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Dec. 26, 1881

9. AGE (In years
last birthday)

68

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kansas City

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jaybus C. Forncrook

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Orpha Bekney, Fairfax, Virginia

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Drowning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

harbor

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Foot of Cromwell Street

21D. TIME (Month) (Day) (Year) (Hour)

Found: Oct. 21, 1950 ? m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently jumped into river. Clothes
found on river bank.22. I certify that I took charge of the remains described above, held an autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

William W. Cook

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct. 23, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Cremation

24B. DATE

10-23-50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county)

Oliver & Greenmount Avenue

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William W. Cook

25. FUNERAL DIRECTOR

ADDRESS

Leo G. Cook, 1701-03 Patterson Park Avenue

VS 151

N990X

164B ✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF TEXAS
COUNTY OF DALLAS

)

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) *Eva d. Wetzel*

2. DATE OF DEATH *Oct 20th 1950*
B. COUNTY _____ before admission)

3. PLACE OF DEATH:

A. Baltimore City, Maryland *1616 E. Federal St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Md*

B. COUNTY _____

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION *—*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto *8-06*

D. STREET ADDRESS (If rural, give location)
1616 E. Federal St

C. Length of stay in Baltimore *Life*

Yrs.
Mos.
Days

5. SEX *Female*

6. COLOR OR RACE *White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH *Feb 4th*

9. AGE (in years last birthday) *66*

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10B. KIND OF BUSINESS OR INDUSTRY *—*

11. BIRTHPLACE (State or foreign country)
Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

David F. Wilson

14. MOTHER'S MAIDEN NAME

Leatherine Hains

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Wm H. Wetzel 1616 E. Federal St

18. *420.0*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *acute coronary thrombosis*

DUE TO

1 hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *arteriosclerotic heart disease*

DUE TO

years 3

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/20/1950* to *10/20/1950*, that I last saw the deceased alive on *10/20/1950* and that death occurred at *1:25 AM*, from the causes and on the date stated above.

23A. SIGNATURE

Maria Friedman

M. O.

23B. ADDRESS

1737 E. North Ave.

23C. DATE SIGNED

10/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial
DATE RECEIVED BY LOCAL REGISTRAR
OCT 23 1950

REGISTRAR'S SIGNATURE
Washington Williams

25. FUNERAL DIRECTOR

ADDRESS

Leo L. Leach 1701-03 N. Patterson Park Ave

[Faint, illegible handwritten text visible through the paper]

5-642
50 9060BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9060

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Amanda H. Schuerholz

2. DATE
OF
DEATH

Oct. 20, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2922 Riggs Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2922 Riggs Ave.

c. Length of stay in Baltimore Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 18, 1888

9. AGE (In years
last birthday)

61

10 Under 1 Year
Months Days

10 2

11 Under 24 Hours
Hours Min.

10 2

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Home Duties

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

August Schuerholz

14. MOTHER'S MAIDEN NAME

Barbara Keys

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

214-01-2915

17. INFORMANT

ADDRESS

Miss Leota Gibbs 2922 Riggs Ave.

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.INTERVAL BETWEEN
ONSET AND DEATH

3 days

6 years

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐

WORK

NOT WHILE ☐

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 18th, 1950, to Oct 20, 1950, that I last saw the
deceased alive on Oct 20, 1950, and that death occurred at P. m., from the causes and on the date stated above.

23A. SIGNATURE

W. Michel

M. D.

23B. ADDRESS

1015 Poplar Grove St.

23C. DATE SIGNED

Oct 21-1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/23/50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

Frederick R. Cole 1913 W. Balto. St.

ADDRESS

87c

545

50 9061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9061

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Walter A.T. Ehmling

Walter EHMLING

2. DATE
OF
DEATH

Oct 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-02

D. STREET ADDRESS (If rural, give location)

4719 Harford Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

July 19, 1886

9. AGE (In years
last birthday)

64

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Type- Finisher

10B. KIND OF BUSINESS OR
INDUSTRY

U.S. Printing office

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

August Ehmling

14. MOTHER'S MAIDEN NAME

Catherine KAMPEB

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

Mrs Katherine Williams

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A) Septicemia, Staph aureus

DUE TO Genicbophallitis

(B) Diabetes Mellitus

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONITION CAUSING IT.

Myocardial Infarction, Post

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 - 1, 1950, to 10 - 20, 1950, that I last saw the
deceased alive on 10 - 19, 1950 and that death occurred at 6:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE

E. W. Demarest

23B. ADDRESS

University Hosp

23C. DATE SIGNED

10-20-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 23, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR'S

Henry Sanders & Sons Baltimore

1899

1899



A-352 50 9062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9062
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Adams, Mrs. Veronica E.</i>			2. DATE OF DEATH <i>10/21/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home & Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 1-03</i>		
c. Length of stay in Baltimore <i>64 Yrs</i>			D. STREET ADDRESS (If rural, give location) <i>2517 Fleet St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>Dec 30, 1885</i>		9. AGE (In years last birthday) <i>64</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Betz</i>			14. MOTHER'S MAIDEN NAME <i>Kunigunda Schliet</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT ADDRESS <i>THOMAS W. ADAMS 2517 FLEET STREET.</i>		
18. <i>153X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cancer of Bowel</i>			CAUSE OF DEATH (A) <i>Cancer of Bowel</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>11 Months</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Diabetes Mellitus</i> DUE TO			(C) <i>Diabetes Mellitus</i>		<i>10 Years</i>
19A. DATE OF OPERATION <i>JAN. 1950</i>		19B. MAJOR FINDINGS OF OPERATION <i>Incomplete Resection of CA of Sigmoid</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Oct 9, 1950</i> , to <i>Sept 21, 1950</i> , that I last saw the deceased alive on <i>Oct 10/21/1950</i> , and that death occurred at <i>12:25 P.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>H. Reed Carroll</i>		23B. ADDRESS <i>Church Home & Hospital</i>		23C. DATE SIGNED <i>10/21/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>OCT 25 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>HOLY REDEEMER CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>4430 BELAIR ROAD MD.</i>		25. FUNERAL DIRECTOR ADDRESS <i>Dyfel Bros. 1800 E Lombard St.</i>			

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9063

BIRTH NO. 50 9063 49-00998

1. NAME OF DECEASED (Type or Print) STERLING RAIKES			2. DATE OF DEATH 10-18-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland BALT. UNIV. HOSP.			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY BI		
B. FULL NAME OF (If not in hospital or institution, give street address or location) UNIVERSITY HOSP.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALT. 25-32		
c. Length of stay in Baltimore 21 Months			D. STREET ADDRESS (If rural, give location) 2815 BOOKER DRIVE		
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1-12-1949		9. AGE (In years last birthday) 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES RAIKES			14. MOTHER'S MAIDEN NAME NANCY ARTIS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT ADDRESS MOTHER 2815 BOOKER DRIVE		

18. 010X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Aspiration of Stomach Contents DUE TO The Meningitis		CAUSE OF DEATH Aspiration	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) Aspiration DUE TO The Meningitis	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) Aspiration of Stomach Contents DUE TO The Meningitis	

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 10-13-50 , 19__, to 10-18-50 , 19__, that I last saw the deceased alive on 10-18-50 , 19__, and that death occurred at 10:30 p.m. , from the causes and on the date stated above.				
23A. SIGNATURE W. G. Emmond		23B. ADDRESS Univ. Hosp.		23C. DATE SIGNED 10-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/23/50	24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary	24D. LOCATION (City, town, or county) (State) A.A. County, Md.
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950	REGISTRAR'S SIGNATURE Wm. H. Williams, Jr.	25. FUNERAL DIRECTOR ADDRESS Chas. Horner 512 Carrollton Ave	

3203

05

OFFICE OF THE ATTORNEY GENERAL

3203

05

EXHIBIT A

OFFICE

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EXHIBIT A

EXHIBIT A

S-530 50 9064

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9064

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES M. SNEED

2. DATE
OF
DEATH

10/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

14-02

D. STREET ADDRESS (If rural, give location)

1510 Brunt St.

c. Length of stay in Baltimore

4.5yrs

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

5/30/1891

9. AGE (In years,
last birthday)

59

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Eastern Shore, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Ellen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Sneed.

ADDRESS

Mary Sneed (W) 1510 Brunt St.

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Myocardial Infarction

DUE TO

(C)

Vascular Disease

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from June 1, 1950, to Oct 20, 1950, that I last saw the
deceased alive on Oct 20, 1950, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

M. E. Sneed

M. D.

23B. ADDRESS

805 N. Brunt St.

23C. DATE SIGNED

10 20 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/24/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem

24D. LOCATION (City, town, or county)

Balto. Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 23 1950

W. H. Williams

Charles Cooper

512 N. Carrollton Ave

VS 150

97024

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20050 9065

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9065

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Reba Lee Hicks

2. DATE
OF
DEATH

10-19-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

5. FULL NAME OF
HOSPITAL OR
INSTITUTION

517 Burgundy St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

22-02

D. STREET ADDRESS (If rural, give location)

517 Burgundy St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female Col.

6. COLOR OR RACE

Single

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

July 17, 1924

9. AGE in years
last birthday

26

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR
INDUSTRY

PRIVATE

11. BIRTHPLACE (State or foreign country)

Grimesland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

German Hicks

14. MOTHER'S MAIDEN NAME

Kizzie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Kizzie Hicks

ADDRESS

Burgundy 517 St.

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-13-1950, to 10-19-1950 that I last saw the
deceased alive on 10-19-1950 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Reba Lee Hicks

M. D.

23B. ADDRESS

2530 - Pa. Ave.

23C. DATE SIGNED

10/20/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-23-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

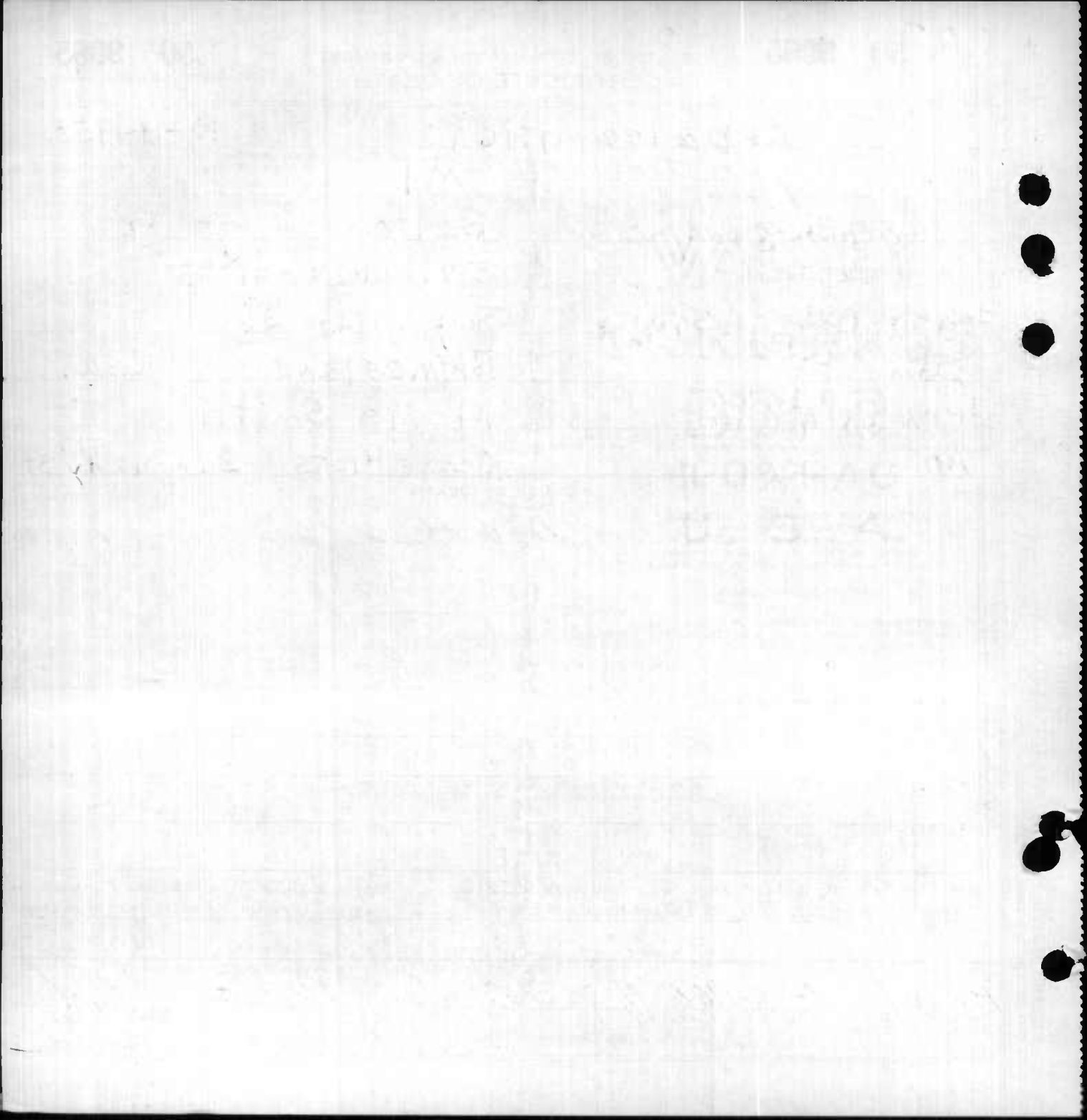
Wilmington Williams

25. FUNERAL DIRECTOR

Mrs. Katie Williams

ADDRESS

3224 Schroeder St.



W-420
Dr. Sawyer

50 9066

50 9066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Isabella Walz

2. DATE
OF
DEATH

Oct. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

5505 Arabia Avenue

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5505 Arabia Avenue

c. Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Feb. 19, 1871

9. AGE (In years
last birthday)

79

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Gail

14. MOTHER'S MAIDEN NAME

Louisa Scherrer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. George Walz. 5505 Arabia Ave.

18. 154x

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of Rectum

DUE TO

5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Generalized arteriosclerosis

5 yrs.

19A. DATE OF OPERATION

Oct. 1, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Rectum - Colostomy

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1944, to Oct. 21, 1950, that I last saw the deceased alive on Oct. 21, 1950, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Leonard J. Ruck

M. D.

23B. ADDRESS

4808 Harford Rd.

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-25-50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

T. W. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road.

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Dr. Harbold

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BALTIMORE CITY HEALTH DEPARTMENT

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9067

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Marie E. Brenneman

2. DATE
OF
DEATH

Oct. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

4709 Elsrode Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

27-02

D. STREET ADDRESS (If rural, give location)

4709 Elsrode Avenue

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDDED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 10, 1909

9. AGE (In years,
last birthday)

41

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Bopp

14. MOTHER'S MAIDEN NAME

Margaret O'Connor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Chas. G. Brenneman, 4709 Elsrode

18. 170X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)Carcinoma of breast
(Primary of breast)INTERVAL BETWEEN
ONSET AND DEATH

8 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Metastasis to pelvis,
spine & liver

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 14, 1950, to Oct 22, 1950, that I last saw the
deceased alive on Oct 21, 1950, and that death occurred at 3:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4706 Harford Road Oct 22, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-25-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balto Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 23 1950

L. J. Ruck, M.D.

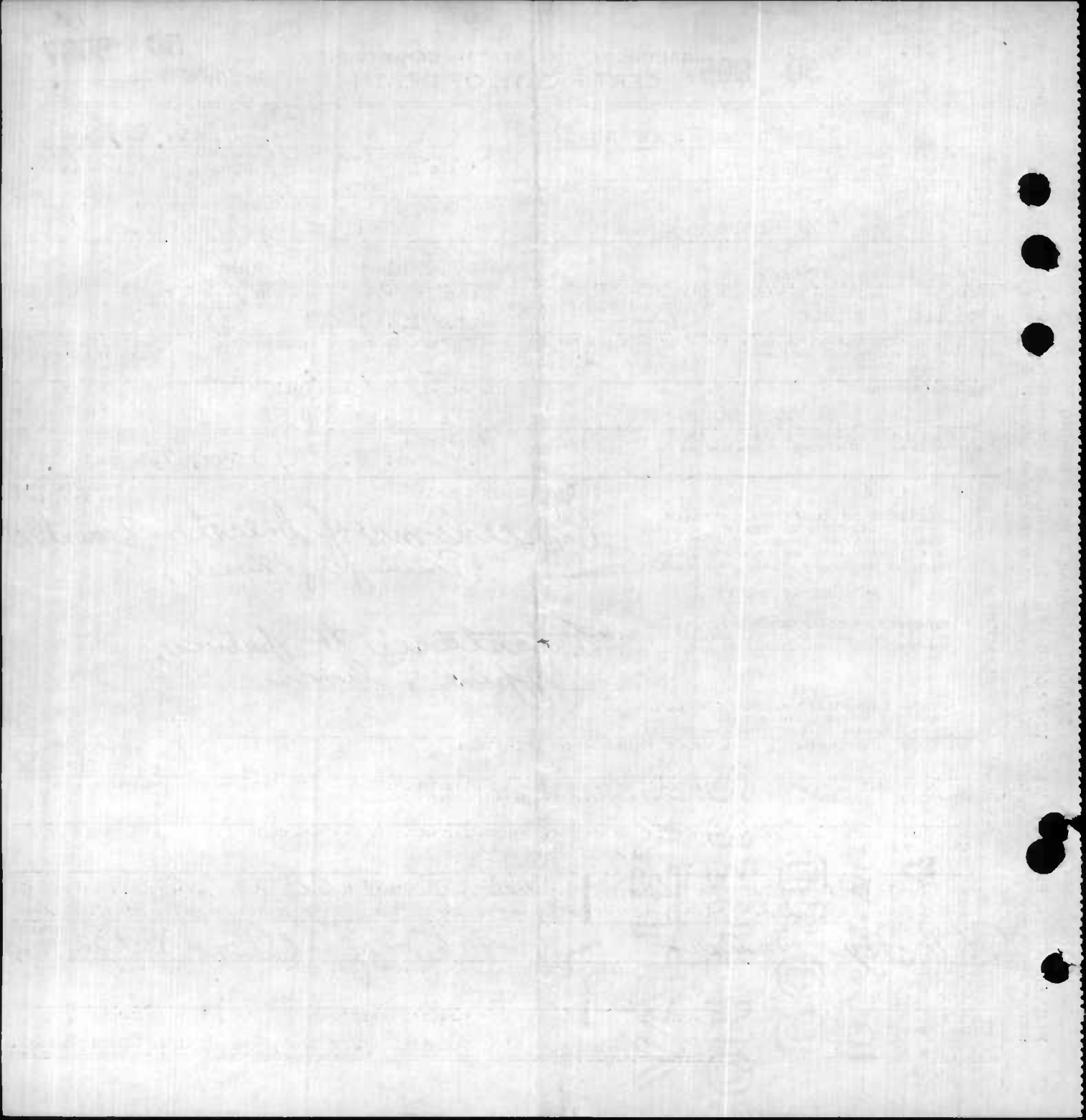
Leonard J. Ruck, 5305 Harford Road.

VS 150

0500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6-452

50 9068

50 9068

REA-142635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____			
1. NAME OF DECEASED (Type or Print) Pelige Nathan Collins			2. DATE OF DEATH Oct. 19, 1950
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
5. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-03	
c. Length of stay in Baltimore ? Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1337 W. North Avenue	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/12/1896
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Ship yard	9. AGE (In years last birthday) 54
11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or ookoowo) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-01-8632	
17. INFORMANT		ADDRESS Records: B. C. H. 4940 Eastern Avenue	
18. 187X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Bladder with Metastases DUE TO (A) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease with failure			INTERVAL BETWEEN ONSET AND DEATH 6 Mos.
19A. DATE OF OPERATION 7		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-18 , 1950, to 10-19 , 1950 that I last saw the deceased alive on 10-19 , 1950, and that death occurred at 10:25 Pm. , from the causes and on the date stated above.			
23A. SIGNATURE <i>P. H. Rogers</i>		23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 10-21-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/20/50	24C. NAME OF CEMETERY OR CREMATORY Mt Auburn
24D. LOCATION (City, town, or county) (State) Md.			
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR Geo. G. Kelson 1303 Presstman St.	
REGISTRAR'S SIGNATURE <i>William M. ...</i>		ADDRESS	

VS 150 31950

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9069

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Emma E. Meister

2. DATE
OF
DEATH

October 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

5002 Frederick Ave.

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

27-48

The Gundry Sanitarium, Balto.

D. STREET ADDRESS (If rural, give location)

820 Cedarcroft Rd.

c. Length of stay in Baltimore

69 years

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

September 22, 1881

9. AGE (In years
last birthday)

69

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

house wife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Ernest Kaestner

14. MOTHER'S MAIDEN NAME

Louisa Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

Mrs. Emilio M. Fraga

ADDRESS

820 Cedarcroft Rd Balto. 12

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

24 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Atherosclerosis + hypertension

DUE TO

Several years

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September 20, 1950, to October 22, 1950, that I last saw the
deceased alive on October 22, 1950, and that death occurred at 3:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Rudolf H. Gundersen

23B. ADDRESS

M. D. The Gundry Sanitarium Balto. 29 Md

23C. DATE SIGNED

Oct. 22, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/24/50

24C. NAME OF CEMETERY OR CREMATORY

Balto. Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 23 1950

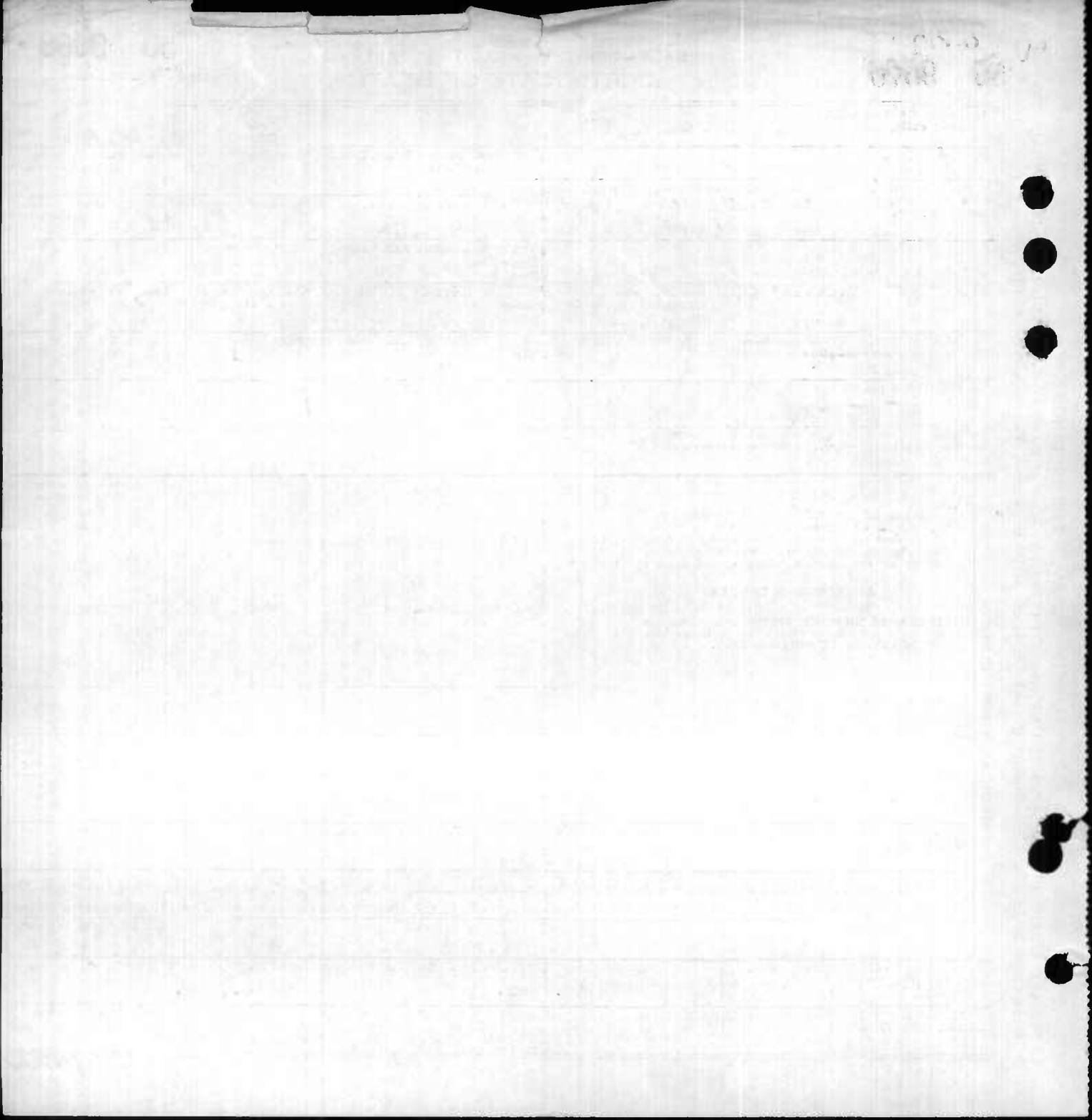
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. Lickner & Sons - Balto. Md.

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9070
Registered No.

BIRTH NO. 50 9070		1. NAME OF DECEASED (Type or Print) JOHN H. DUNCAN		2. DATE OF DEATH Oct. 20, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1829 E. 31st St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-06		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1829 E. 31st St.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 11, 1866		9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10B. KIND OF BUSINESS OR INDUSTRY Bank	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland
13. FATHER'S NAME Henry F. Duncan			14. MOTHER'S MAIDEN NAME Virginia Morgan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 212-14-2497	17. INFORMANT ADDRESS Mr. Roy Duncan - 500 Hatherleigh Rd.		
18. 177x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of Prostate DUE TO (B) old age + Exhaustion (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH 1-yr
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-2:00 p.m., 1950, to 10-20, 1950, that I last saw the deceased alive on 10-20, 1950, and that death occurred at 10:30 p.m., from the causes and on the date stated above.					
23A. SIGNATURE Stokely C. Blake		23B. ADDRESS Med. Arts Bldg		23C. DATE SIGNED 10-23-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/24/50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		24E. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		24F. LOCATION (City, town, or county) (State) Balto., Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR Thos. J. Sweeney & Sons - Balto. Md.	

CTUC - IN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

To be approved.

50 9071 BALTIMORE CITY HEALTH DEPARTMENT 50 9071

CERTIFICATE OF DEATH Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Edward Colliflower		2. DATE OF DEATH Oct. 20, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Fetterhoff Nursing Home 3502 Clifton Ave.,		C. CITY OR TOWN (If outside corporate limits, write city and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3027 Clifton Ave.,	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 3/17/1873
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hotel Clerk		10B. KIND OF BUSINESS OR INDUSTRY Westminster Hotel	9. AGE (In years last birthday) 77 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
13. FATHER'S NAME Jago Colliflower		11. BIRTHPLACE (State or foreign country) Md. CERTIFICATION APPROVED BY John R. Davis, MD.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME per: Agnes C. Weller CHIEF OR ASSI. MEDICAL EXAMINER	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS J. Clayton Colliflower 1600 Ingleside Ave.	
18. E902.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism DUE TO A. Pulmonary embolism 15 min. B. Fracture of right femur 7 days. C. Cerebral thrombosis 6 mos. D. Cerebral thrombosis 6 mos.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION None		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident		21B. PLACE OF INJURY (a. g., in or about home, farm, factory, street, office bldg., etc.) in home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3027 Clifton Ave. Baltimore Md.		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Oct. 13, 1950 - 8:00 A. m.	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell to floor while getting out of bed.	
22. I hereby certify that I attended the deceased from Feb 7, 1948 , to Oct. 20, 1950 , that I last saw the deceased alive on Oct. 20, 1950 , and that death occurred at 10:45 p.m. , from the causes and on the date stated above.			
23A. SIGNATURE Abraham B. Hurwitz		23B. ADDRESS 3048 W. North Ave.	
23C. DATE SIGNED Oct. 23 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-24-50	
24C. NAME OF CEMETERY OR CREMATORY Western		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE W. H. Williams	
25. FUNERAL DIRECTOR G. Howard Strong		ADDRESS 3207 W. North Ave.,	

VS 150 **N 821.0** **186a**

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CERTIFICATE CORRECTED 10-25-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9072

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Frank Sanders

2. DATE
OF
DEATH

Oct 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Long Hall 6

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

md

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

208 N. Calver St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

4-1-1910

9. AGE (In years
last birthday)

40

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

DETECTIVE

10B. KIND OF BUSINESS OR
INDUSTRY

CITY POLICE DEPT

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Sanders

14. MOTHER'S MAIDEN NAME

WILHELMINA KROENING

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

754.1
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) CHOLEMIA

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

BILIARY CIRRHOSIS

DUE TO

(C) EXTRAHEPATIC BILIARY OBSTRUCTION

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

ESOPHAGEAL VARICES

19A. DATE OF OPERATION

10/13/50

19B. MAJOR FINDINGS OF OPERATION

ABSENCE OF PATENT EXTRAHEPATIC DUCTS

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-9-1950 to 10-21-1950, that I last saw the
deceased alive on 10-21, 1950, and that death occurred at 2:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Arthur R. Nelson M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10/21/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 24/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

ADDRESS

Rita Wredfeld 900 E. Biddle St



P-400
50 9073BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9073

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Poole, Miss Hattie

2. DATE
OF
DEATH

Oct 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

5300

D. STREET ADDRESS (If rural, give location)

Paradise Road & ALVAMONT

c. Length of stay in Baltimore

79 Years

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 7, 1871

9. AGE (In years
last birthday)

79

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Poole

14. MOTHER'S MAIDEN NAME

Mary Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 443X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebral Hemorrhage

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-vascular Disease

DUE TO

Many Years

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY: (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/20, 1950, to 10/22, 1950, that I last saw the
deceased alive on 10/22, 1950, and that death occurred at 7:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

W Reed Carroll

M. D.

23B. ADDRESS

Church Home & Hospital

23C. DATE SIGNED

10/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 20-50

24C. NAME OF CEMETERY OR CREMATORY

St Ignatius Cem

24D. LOCATION (City, town, or county) (State)

Belair Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John D. Mitchell & Sons

1900 Eutaw Pl.

093d

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9074

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Leonard Muller

2. DATE
OF
DEATH

Oct. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

4308 Highland Ave

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

4308 Highland

5. SEX

M

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept 30

9. AGE (In years
last birthday)

69

H Under 1 Year
Months: DaysH Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Carpenter (CONST)

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

American

13. FATHER'S NAME

Frederick Muller

14. MOTHER'S MAIDEN NAME

Don't know

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

John Leonard Muller 4308 Highland

18. 177x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of prostate

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Metastases to bones

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

Biopsy of rib at John Hopkins Hospital - malignancy

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to Oct. 20, 1950, that I last saw the deceased alive on Oct. 20, 1950, and that death occurred at 6 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Robert Liberto

23B. ADDRESS

3508 Bank St.

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Oct 24/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Frederick Muller

25. FUNERAL DIRECTOR

ADDRESS

Muller Funeral Home 2004 Glean



Small, faint, illegible text at the bottom of the page, possibly bleed-through from the reverse side.

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 9075**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alexander Kidd

2. DATE
OF
DEATH

10/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland *25th Port St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

at Residence Port St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt

6-02

C. Length of stay in Baltimore

Balt Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

25th Port St

5. SEX

M

6. COLOR OR RACE

M

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1867

9. AGE (In years last birthday)

83

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Boat Repair

10B. KIND OF BUSINESS OR INDUSTRY

Rail road

11. BIRTHPLACE (State or foreign country)

Balt Md

12. CITIZEN OF WHAT COUNTRY

America

13. FATHER'S NAME

Robert Kidd

14. MOTHER'S MAIDEN NAME

Don't know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Margaret Kidd 25th Port St

18. *331X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Static pneumonia (terminal)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(Hemiparesis, paralytic) Brain due to arteriosclerosis

(C)

Paralytic Agitation

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

pu & arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☒
WORK AT WORK

22. I hereby certify that I attended the deceased from *9/1*, 19*49*, to *10/20*, 19*50*, that I last saw the deceased alive on *10/20*, 19*50*, and that death occurred at *11:15 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE

Donald W. Muntz

23B. ADDRESS

3009 Evergreen Ave

23C. DATE SIGNED

10/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct 24/50

24C. NAME OF CEMETERY OR CREMATORY

Balt Cem

24D. LOCATION (City, town, or county)

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

OCT 23 1950

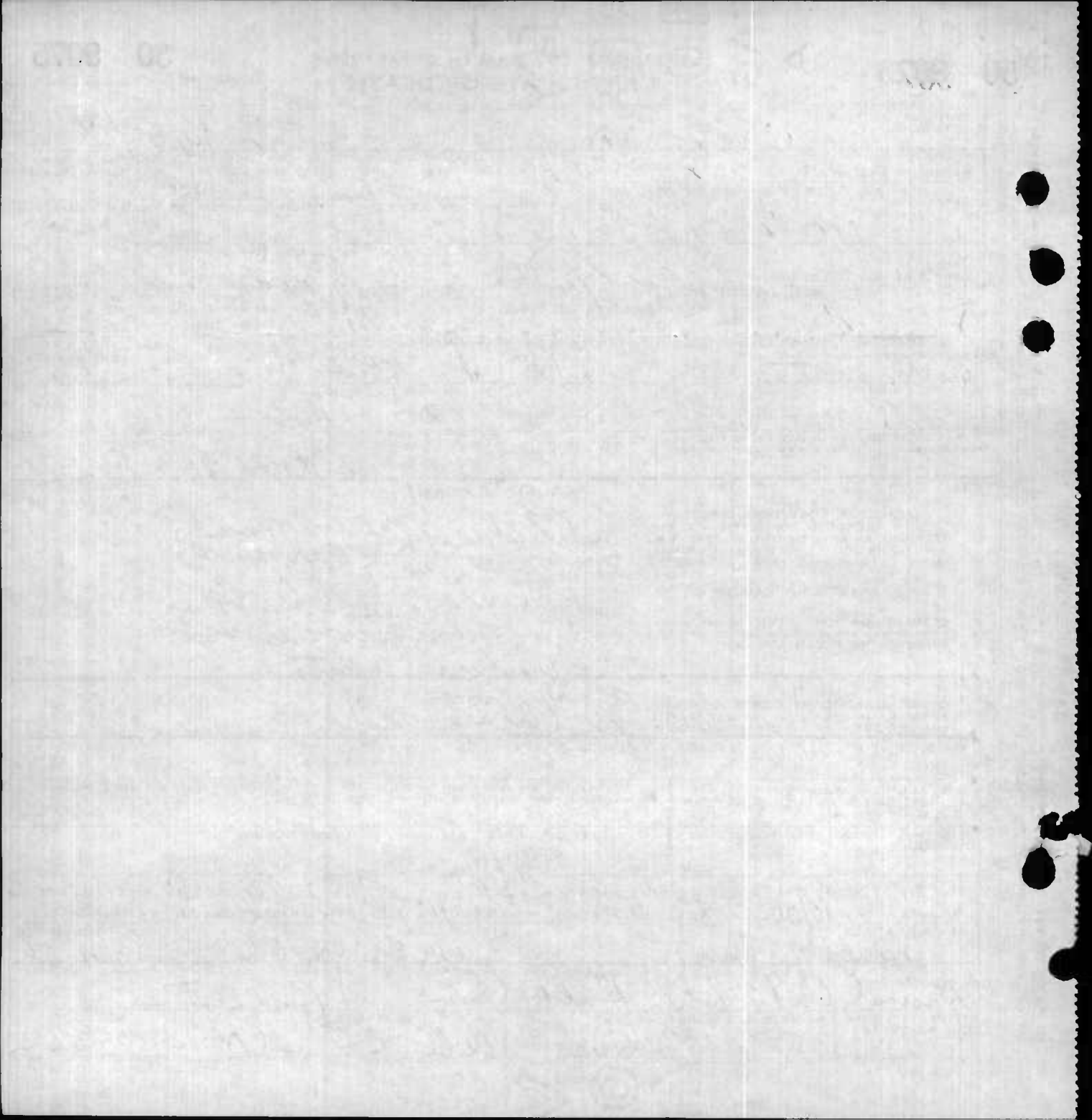
REGISTRAR'S SIGNATURE

Wilmington Williams, Md

25. FUNERAL DIRECTOR

Willink Funeral Home 2004 Calver

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9076

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NANNAH Quaid

2. DATE
OF
DEATH

10-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

141 S. MONASTERY AVE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

20-07

c. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

141 S. MONASTERY AVE

SEX

FEMALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

? 1870

9. AGE (in years

last birthday)

80

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

PATRICK Quaid

14. MOTHER'S MAIDEN NAME

BRIGED BARRY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

JOHN Flaherty 141 S. MONASTERY AVE

ADDRESS

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arteriosclerosis Heart Disease

3 m

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 10, 1949, to Oct 21, 1950 that I last saw the deceased alive on Oct 21, 1950 and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 23 1950

VS 150

693 d

J. M. Walter

[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9077
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Pauline Baker

2. DATE
OF
DEATH

10-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

729 S. Glover Street

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, Md.

D. STREET ADDRESS (If rural, give location)

729 S. Glover Street

C. Length of stay in Baltimore

68yrs

Yrs.
Mos.
Days

5. SEX

F.

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

6-31-62

9. AGE (In years
last birthday)

88

10 Under 1 Year
Months Days

11 Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

?

Mundt

14. MOTHER'S MAIDEN NAME

?

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Gustave Baker

729 S. Glover Street

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

arteriosclerotic cardiovascular disease

INTERVAL BETWEEN
ONSET AND DEATH

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK

NOT WHILE
AT WORK

22. I hereby certify that I attended the deceased from 10/1/1950 to 10/21/1950, that I last saw the deceased alive on 10/21/1950, and that death occurred at 9:30 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Stanley B. Klyanowicz, M.D.

3500 Erdman Ave

10/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-24-50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 23 1950

William H. Williams, Jr.

403 S. Wolfe Street

5077

5077

10-21-50

Pauline Baker

Baltimore

Baltimore, Md.

720 E. Dover Street

720 E. Dover Street

Phone

88

4-1-52

Address

121

Germany

House

Phone

720 E. Dover Street

Pauline Baker

Handwritten notes and signatures

Baltimore, Md.

One hour

10-2-50

Bureau

107 S. Wolfe St.

Handwritten signature

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9078

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Mrs Barbara Ann Meyers</i>		2. DATE OF DEATH <i>10/23/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland - <i>St Joseph's Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Joseph's Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>26-01</i>	
C. Length of stay in Baltimore <i>62 years</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>4222 Berger Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/7/88</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <i>62</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME _____		14. MOTHER'S MAIDEN NAME <i>Wilk</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Son - George Meyers</i>		ADDRESS <i>4222 Berger Ave</i>	

18. <i>260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>Pneumonia - hypostatic</i>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) <i>Uremia</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <i>Diabetes Mellitus</i>		
19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>10-17</i> , 19 <i>50</i> , to <i>10-23</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>10-23</i> , 19 <i>50</i> , and that death occurred at <i>12:20 am.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Edmund Paul Coffey Jr.</i> M.D.	23B. ADDRESS <i>St Joseph's Hospital</i>	23C. DATE SIGNED <i>10/23/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10-26-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	25. FUNERAL DIRECTOR <i>Lilly & Zeller Inc.</i> ADDRESS <i>403 S. Wolfe St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>Oct 23 1950</i> REGISTRAR'S SIGNATURE <i>Washington Williams</i>		

8509 06

8509 06



V-532
50 9079BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9079
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MAX von MITZELL

2. DATE
OF
DEATH

Oct. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONSt. Paul Convalescent Home
2305 St. Paul St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write FULL and give township)
Balto.

D. STREET ADDRESS (If rural, give location)

1001 St. Paul St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Oct. 26, 1869

9. AGE (In years—
last birthday)

80

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Telephone Operator

10B. KIND OF BUSINESS OR INDUSTRY

Telephone

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Alexander von Mitzell

14. MOTHER'S MAIDEN NAME

Wilhelmia Frey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. W. Murdock Bagnell-3312 Walbrook Ave.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Arteriosclerotic Cardio. Vascular
Disease 4 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-10, 1950 to 10-22, 1950, that I last saw the deceased alive on 10-22, 1950, and that death occurred at 3 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)DATE RECEIVED BY
LOCAL REGISTRAR

24B. DATE

10/24/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

25. FUNERAL DIRECTOR

ADDRESS

OCT-23-1950

VS 150

093d Md.

0708 06

0708 06



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9080

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Venera Catalano

2. DATE
OF
DEATH

Oct. 21st. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 623 W. Hamburg St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

623 W. Hamburg St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 29 1881

9. AGE (In years
last birthday)

69

10 Under 1 Year
Months: Days

3

11 Under 24 Hours
Hours: Min.

22

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Sicily Italy

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Vincenzo Mancuso

14. MOTHER'S MAIDEN NAME

Carmela ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Giuseppe Catalano 623 W. Hamburg St.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertension

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Hypertensive Cardiovascular
Disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 19, 1950, to Oct. 21, 1950; that I last saw the
deceased alive on Oct. 21, 1950, and that death occurred at 2 A. M., from the causes and on the date stated above.

23A. SIGNATURE

W. E. Needle

M. D.

23B. ADDRESS

2114 - Dr. North Ave

23C. DATE SIGNED

10/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 24 1950 New Cathedral Cem.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

4300 Old Frederick Rd.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

W. E. Needle

25. FUNERAL DIRECTOR

ADDRESS

Frank Della Noce 322 S. High St.

1933

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9081

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NANDO NANDO STERNINI STERNINI

2. DATE
OF
DEATH

October 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2030 Eastern Avenue

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Aug. 24 1926

9. AGE (In years
last birthday)

24

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

NEVER WORKED

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

ROLAND STERNINI

14. MOTHER'S MAIDEN NAME

MARY ADEVAIA

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

NAVY

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS JULIA MONACO 6807 5th Ave

B. E984X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple gunshot wounds of chest and
extremities with massive hemothorax

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Store

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Acme Food Store, 520 E. Belvedere Ave.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Oct. 21, 1950 12:20 A. M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

William Williams

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

10-21-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10-24-1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

4430 Belair Rd

(State)

Baltimore

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Frank Bellis

ADDRESS

322 S. High St

VS 151

N904.4

166.0

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1883 05

DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1883 05

NAME: STERN, ROLAND

Age: 34

Place of Birth: ALABAMA

Occupation: MRS. JULIA MONROE

NAME: ROLAND STERN

NAVY

10-24-1883
12-11-1883

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9082
Registered No. _____

50 9082

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Hattie McCellan Butler

2. DATE
OF
DEATH

10/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

104 W. York St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write R.U.M. and give township)

D. STREET ADDRESS (If rural, give location)

104 W. York St.

c. Length of stay in Baltimore

20 Yrs.
Mos.
Days

5. SEX

F.

6. COLOR OR RACE

Colored.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

11-25-1901

9. AGE (in years

last birthday)

49

If Under 1 Year

Months; Days

If Under 24 Hours

Hours; Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Madison Co. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jack Williams

14. MOTHER'S MAIDEN NAME

unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Annie Robinson 51 May 3. St

18. *141X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) *Carcinoma of Tongue -*
DUE TO *local invasion - metastases*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

?

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

Biopsy Lymph node of neck - CA Squamous Cell

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *5/18*, 1950 to *8/31*, 1950, that I last saw the
deceased alive on *8/31*, 1950, and that death occurred at *8:05* A.M., from the causes and on the date stated above.

23A. SIGNATURE

R. G. Felt

23B. ADDRESS

SBGH 1213 Light St

23C. DATE SIGNED

10/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

10-27-50

24C. NAME OF CEMETERY OR CREMATORY

Wm. A. Graham Bury

24D. LOCATION (City, town, or county)

Balt. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 23 1950

REGISTRAR'S SIGNATURE

109-5000

25. FUNERAL DIRECTOR

W. H. Spriggs

ADDRESS

139 W. Hamlet St

VS 150

0456

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11-26-11
 10:00 AM
 10:00 AM

10:00 AM
 10:00 AM

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9083**

1. NAME OF DECEASED (Type or Print) CLARA FRANCES WOODS			2. DATE OF DEATH October 20, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Victory Villa Gardens, Middle River		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 14 N. Randolph Rd. 5300		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 22, 1918	9. AGE (In years last birthday) 32	II Under 1 Year Months: _____ Days: _____ II Under 24 Hours Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Jefferson, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William A. Shepherd			14. MOTHER'S MAIDEN NAME Mattie Hoffman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Letcher V. Woods 14 Randolph Rd. Balto. Co.		

18. E976X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) Gunshot injury of the chest DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 14 N. Randolph Rd.	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Oct. 20, 1950 11:50 A.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Firearms	
22. I certify that I took charge of the remains described above, held an <u>Inspection & Inq.</u> thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE R. Fisher		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED Oct. 21, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE October 24, 1950	24C. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		24D. LOCATION (City, town, or county) (State) Shucks' Corner, Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE William Williams		25. FUNERAL DIRECTOR ADDRESS Charles S. Zeiler. 901 S. Conkling St.	

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of Health Officer		15. Signature of City Clerk	
16. Signature of Burial Officer		17. Signature of Undertaker		18. Signature of Funeral Home		19. Signature of Cemetery		20. Signature of Burial Place	
21. Signature of Burial Place		22. Signature of Burial Place		23. Signature of Burial Place		24. Signature of Burial Place		25. Signature of Burial Place	
26. Signature of Burial Place		27. Signature of Burial Place		28. Signature of Burial Place		29. Signature of Burial Place		30. Signature of Burial Place	
31. Signature of Burial Place		32. Signature of Burial Place		33. Signature of Burial Place		34. Signature of Burial Place		35. Signature of Burial Place	
36. Signature of Burial Place		37. Signature of Burial Place		38. Signature of Burial Place		39. Signature of Burial Place		40. Signature of Burial Place	
41. Signature of Burial Place		42. Signature of Burial Place		43. Signature of Burial Place		44. Signature of Burial Place		45. Signature of Burial Place	
46. Signature of Burial Place		47. Signature of Burial Place		48. Signature of Burial Place		49. Signature of Burial Place		50. Signature of Burial Place	
51. Signature of Burial Place		52. Signature of Burial Place		53. Signature of Burial Place		54. Signature of Burial Place		55. Signature of Burial Place	
56. Signature of Burial Place		57. Signature of Burial Place		58. Signature of Burial Place		59. Signature of Burial Place		60. Signature of Burial Place	
61. Signature of Burial Place		62. Signature of Burial Place		63. Signature of Burial Place		64. Signature of Burial Place		65. Signature of Burial Place	
66. Signature of Burial Place		67. Signature of Burial Place		68. Signature of Burial Place		69. Signature of Burial Place		70. Signature of Burial Place	
71. Signature of Burial Place		72. Signature of Burial Place		73. Signature of Burial Place		74. Signature of Burial Place		75. Signature of Burial Place	
76. Signature of Burial Place		77. Signature of Burial Place		78. Signature of Burial Place		79. Signature of Burial Place		80. Signature of Burial Place	
81. Signature of Burial Place		82. Signature of Burial Place		83. Signature of Burial Place		84. Signature of Burial Place		85. Signature of Burial Place	
86. Signature of Burial Place		87. Signature of Burial Place		88. Signature of Burial Place		89. Signature of Burial Place		90. Signature of Burial Place	
91. Signature of Burial Place		92. Signature of Burial Place		93. Signature of Burial Place		94. Signature of Burial Place		95. Signature of Burial Place	
96. Signature of Burial Place		97. Signature of Burial Place		98. Signature of Burial Place		99. Signature of Burial Place		100. Signature of Burial Place	

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9084

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9084

Registered No.

BIRTH NO. 50-28391

1. NAME OF DECEASED (Type or Print) BABY			2. DATE OF DEATH September 18, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION 1628 Ellsworth Street			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) 1628 Ellsworth Street		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N			10b. KIND OF BUSINESS OR INDUSTRY		
11. FATHER'S NAME K			12. MOTHER'S MAIDEN NAME N		
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) W			14. SOCIAL SECURITY NO.		
15. ADDRESS			16. ADDRESS		

18. 754.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Congenital heart disease (A) DUE TO ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William W. Fisher</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Sept. 19, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 10/5/50		24C. NAME OF CEMETERY OR CREMATORY Baltimore City	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR Dr. R. S. Fisher		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE <i>William W. Fisher</i>		VS 151	

Completed at *Harvey* 10/5/50 1572 ✓

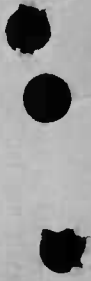
1808

02

DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1808

02



E-430 50 9085

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9085

BIRTH NO. 50-22391

1. NAME OF DECEASED
(Type or Print)

Baby Girl Elliott

2. DATE
OF
DEATH

10-15-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

U. H.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY

B. Md.

Balt.

- before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

U. H.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt.

D. STREET ADDRESS (If rural, give location)

603 N. Stuehr

7-01

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10-15-50

9. AGE (In years
last birthday)

0

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.

10 45

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

James Elliott

14. MOTHER'S MAIDEN NAME

Jean Elliott White

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mother

18. 761.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Extreme Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Premature rupture membranes

DUE TO

(C)

Unknown

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-15-50 7:35 AM, to 10-15-50 6 AM, that I last saw the
deceased alive on 5 PM, 1950, and that death occurred at 6 PM, from the causes and on the date stated above.

23A. SIGNATURE

William H. Bauman

M. D.

23B. ADDRESS

New Hope

23C. DATE SIGNED

10-15-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 16 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 23 1950

William H. Bauman

Commissioner of Health

VS 150

160 c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VALLEY

CORPORATION

INCORPORATED

IN THE STATE OF

NEW YORK

CHARTERED JANUARY 1, 1901

OFFICE OF THE

SECRETARY

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

630

50 9086

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9086

Registered No.

BIRTH NO. 50-21992

1. NAME OF DECEASED (Type or Print) <i>Pratt, Baby Girl</i>			2. DATE OF DEATH <i>10-12-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore, Md. 18-03</i>		
c. Length of stay in Baltimore <i>1</i> Yrs. <i>1</i> Mos. <i>1</i> Days			D. STREET ADDRESS (If rural, give location) <i>867 Boye St</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>10-11-50</i>	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>John W. Hoag</i>			14. MOTHER'S MAIDEN NAME <i>Evelyn Rawlings</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or oknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Eva R. Pratt</i>		

18. <i>776 X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>prematurity</i> DUE TO			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES (B) _____ DUE TO								
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) _____								
19A. DATE OF OPERATION <i>0</i>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <i>10/11</i> , 19 <i>50</i> , to <i>10/11/50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>10/12</i> , 19 <i>50</i> , and that death occurred at <i>11:50</i> m., from the causes and on the date stated above.								
23A. SIGNATURE <i>J. E. Jernan</i>			23B. ADDRESS <i>University Hosp.</i>			23C. DATE SIGNED <i>10/12/50</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)		
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 23 1950</i>		REGISTRAR'S SIGNATURE <i>Walter H. Williams</i>		25. FUNERAL DIRECTOR <i>Commissioner of Health</i>		ADDRESS		

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **50 9087**

BIRTH NO. **50-22378**

1. NAME OF DECEASED
(Type or Print) **Baby Girl Hart**

2. DATE OF DEATH **Oct. 18, 1950**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION **Sinai Hospital**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 2-01

c. Length of stay in Baltimore **35 hrs.**
Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)
2034 Eastern Ave. # 31

5. SEX
Female

6. COLOR OR RACE
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
S

8. DATE OF BIRTH
Oct. 17, 1950

9. AGE (In years last birthday) If Under 1 Year Months Days If Under 24 Hours Hours Min.
35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Harley Gene Hart

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Jarmans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mother, Mrs Elizabeth Hart

18. **776x**

CAUSE OF DEATH

2034 Eastern Ave. # 31

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Prematurity and Immaturity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10-17** 19**50**, to **10-18**, 19**50**, that I last saw the deceased alive on **10-18**, 19**50**, and that death occurred at **4:50** p.m., from the causes and on the date stated above.

23A. SIGNATURE

Judith L. Landon

M. D.

23B. ADDRESS

Sinai Hospital, Baltimore

23C. DATE SIGNED
10-19

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL OCT 20 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNDING AGENCY

ADDRESS

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9088
Registered No.1. NAME OF DECEASED
(Type or Print)

SYER J. SONSTENG

2. DATE
OF
DEATH

October 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

also B. COUNTY

before admission)

Maryland

Minnesota

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2003 Gough Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore

Roseau township)

D. STREET ADDRESS (If rural, give location)

2003 Gough Street Route #2, Box 9

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

white

6. COLOR OR RACE

male

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Oct. ?

9. AGE (In years

last birthday)

40

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant Seaman

10B. KIND OF BUSINESS OR INDUSTRY

Maritime

11. BIRTHPLACE (State or foreign country)

Minnesota

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob Sonsteng

14. MOTHER'S MAIDEN NAME

Lena ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Kveen & Listug Funeral Home, Roseau, Minn.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Doulach

23B. CHIEF MEDICAL EXAMINER..... ☐ASSISTANT MEDICAL EXAMINER..... ☒MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED

Oct. 19, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

removal

24B. DATE

10/24/50

24C. NAME OF CEMETERY OR CREMATORY

-

24D. LOCATION (City, town, or county)

Roseau, Minn.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

Wm. J. Dickner & Sons

ADDRESS

OCT 23 1950

673 55

094a

M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8808 05

RECEIVED BY POSTAL SERVICE
DEPT. OF HEALTH

8808 05



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9089

Registered No. _____

BIRTH NO. _____		
1. NAME OF DECEASED (Type or Print) JAMES LAWTON		2. DATE OF DEATH September 18, 1950
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Florida B. COUNTY V-08
5. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Panpano Beach
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location)
6. SEX male	7. COLOR OR RACE colored	8. DATE OF BIRTH Unknown
9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Unknown	10. AGE (In years last birthday) 60?	11. Under 1 Year Months: _____ Days: _____ 12. Under 24 Hours Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Unknown
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT ADDRESS Unknown

18. E 983x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Depressed skull fracture DUE TO Antecedent causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Epidural hemorrhage DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH Depressed skull fracture Epidural hemorrhage	INTERVAL BETWEEN ONSET AND DEATH
---	--	---	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fawn St. and East Falls Avenue		
21D. TIME (Month) (Day) (Year) (Hour) Found: September 18, 1950	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Apparently struck on head by blunt instrument thereon and from		
22. I certify that I took charge of the remains described above, held an autopsy Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE <i>William J. Smith</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....	23C. DATE SIGNED Sept. 18, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL OCT 3, 1950	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950	REGISTRAR'S SIGNATURE <i>Commissioner of Health</i>	25. FUNERAL DIRECTOR ADDRESS Commissioner of Health		

VS 151 N803.2

168.0

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

TO: [Illegible]
FROM: [Illegible]
SUBJECT: [Illegible]
DATE: [Illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report with several paragraphs of text.]

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT



50 9090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9090
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM L. THOMPSON

2. DATE
OF
DEATH

September 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Unknown

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Unknown

8. DATE OF BIRTH

Unknown

9. AGE (In years
last birthday)

29

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Unknown

18. 581.0, 490X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Lobar pneumonia

DUE TO

ANTECEDENT CAUSES

(B) Fatty liver

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Dureacher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

Sept. 7, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 3 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

VS 151

108.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 3030

50 3030



M-625 50 9091

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9091
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RUSSELL B. MORGAN

2. DATE
OF
DEATH

September 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

U

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
location)HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN

N

(If outside corporate limits, write RURAL and give
township)

K

D. STREET ADDRESS (If rural, give location)

O

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

white

6. COLOR OR RACE

male

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

W

N

9. AGE (In years
last birthday)

60

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

U

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

U

N

13. FATHER'S NAME

N

K

14. MOTHER'S MAIDEN NAME

N

K

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

OWN

16. SOCIAL
SECURITY NO.

17. INFORMANT

W

ADDRESS

18. 322.0

CAUSE OF DEATH N

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute alcoholism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. [Signature]

23B. CHIEF MEDICAL EXAMINER.....☒ASSISTANT MEDICAL EXAMINER.....☒

M.D.

MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Sept. 28, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 151

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✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

UNIVERSITY MEDICAL SCHOOL

OCT 3 1950

Commissioner of Health

1009

30

BIRMINGHAM CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1009 30

CAUSE OF DEATH

BIRTH NO.				Baltimore City Health Department				Registered No.			
1. NAME OF DECEASED (Type or Print)				LOUIS BEAFORT				2. DATE OF DEATH OCTOBER 6, 1950			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland				B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 422 S. Caroline Street			
c. Length of stay in Baltimore				Yrs. Mos. Days							
5. SEX Male		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U		8. DATE OF BIRTH U		9. AGE (In years last birthday) 35		10. Under 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY K				11. BIRTHPLACE (State or foreign country) K			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME N O				14. MOTHER'S MAIDEN NAME W			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO. N				17. INFORMANT ADDRESS			
18. 490X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH (A) Lobar Pneumonia DUE TO (B) Empyema, right lung DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK				21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .											
23A. SIGNATURE William H. ...				23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....				23C. DATE SIGNED 10-6-50			
24A. BURIAL, CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY			
24D. LOCATION (City, town, or county)				24E. (State)							
DATE RECEIVED BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE				25. FUNERAL DIRECTOR			
								ADDRESS			

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

NO. 1000

DATE OF DEATH

CAUSE OF DEATH

1. (Immediate Cause)

2. (Underlying Cause)

3. (Manner of Death)

4. (Place of Death)

5. (Occupation)

6. (Education)

7. (Marital Status)

8. (Other Information)

50 9093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9093

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HELEN JORDAN

2. DATE
OF
DEATH

11 OCTOBER 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
A. STATE B. COUNTY before admission)

914 N. Franklin St.

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

Good Samaritan Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore, Md. 18-01

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

7

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

12-25-04

9. AGE (In years
last birthday)

45

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 174X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Carcinoma of uterus

(A)

DUE TO

Generalized metastases

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

8 mo.

3 mo.

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 23, 1950, to Oct. 11, 1950, that I last saw the
deceased alive on Oct 9, 1950 and that death occurred at 10 A.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Edwin Muller

23B. ADDRESS

2301 Reed St

23C. DATE SIGNED

11 Oct 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 13 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

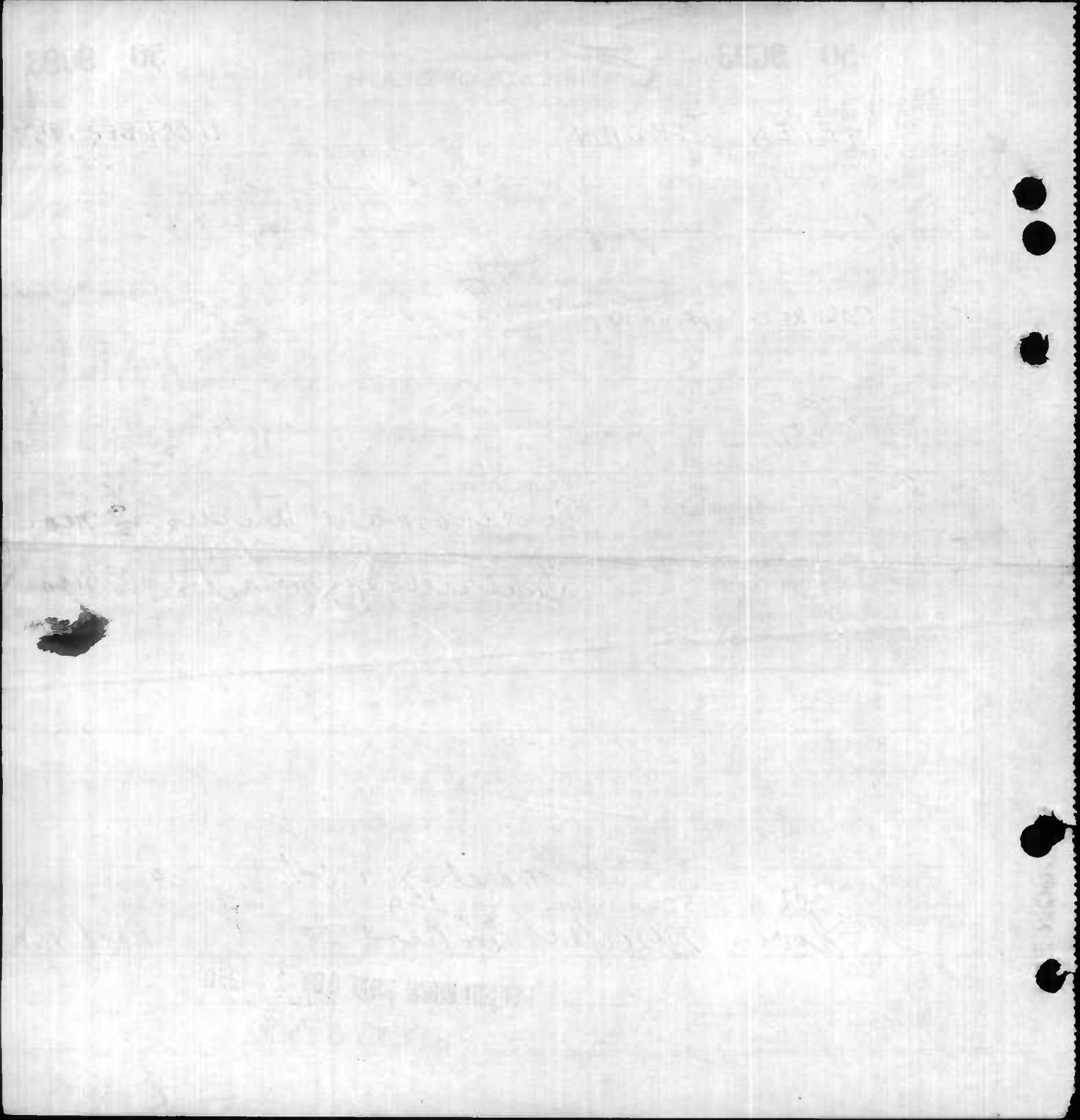
OCT 23 1950

The University of Maryland, Baltimore

Commissioner of Health

VS 150

0486



320
REG-28692

50

9094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

9094

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Samuel Coates

2. DATE
OF
DEATH

9-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONBaltimore City Hospitals
4940 Eastern Avenue4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

No Home

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 8, 1885

9. AGE (in years
last birthday)

65

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Amelia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18. 002X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Pulmonary Tuberculosis

INTERVAL BETWEEN
ONSET AND DEATH

over 1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Thrombosis

Syphilitic Heart Disease

10 yrs.

15 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 11-30, 1937, to 9-22, 1950, that I last saw the deceased alive on 9-22, 1950, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 4 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1908

CO

1908

CO



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9095
Registered No. _____

BIRTH NO. _____		50 9095	
1. NAME OF DECEASED (Type or Print) REGINA KATTEN.		2. DATE OF DEATH OCTOBER 22-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 3208 GARRISON AVE.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE XXXXXXXXXXXX COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION XXXXXXXXXXXX		C. CITY OR TOWN (If outside corporate limits, write FULL and give township) BALTIMORE-MD	
c. Length of stay in Baltimore XXXXXXXX Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3208 GARRISON AVE -CITY.	
5. SEX FEMALE.	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH APRIL-6-1878
9. AGE (In years, Months, Days) 72		10. Under 1 Year 6	11. Under 24 Hours 16
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX		10B. KIND OF BUSINESS OR INDUSTRY XXX	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U-S-A	
13. FATHER'S NAME LEVI KATTEN		14. MOTHER'S MAIDEN NAME MARY-(DONT KNOW)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) XX		16. SOCIAL SECURITY NO. X	
17. INFORMANT MRS JANE KATTEN-3504 LIBERTY HEIGHTS		ADDRESS _____	
18. 443X I 1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) acute coronary Thrombosis DUE TO Sudden			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Hypertensive Arteriosclerotic cardiovascular disease DUE TO grad			
(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1948 , to 10/22 , 19 50 , that I last saw the deceased alive on 10/17 , 19 50 , and that death occurred at 4:19 m., from the causes and on the date stated above.			
23A. SIGNATURE Theresa B. Katten		23B. ADDRESS 2320 Suburban	
23C. DATE SIGNED 10/23/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE OCT 24th-1950	
24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BELAIR RD	
DATE RECEIVED BY LOCAL REGISTRAR OCT 23 1950		REGISTRAR'S SIGNATURE J. AHRENS CO 2432	
25. FUNERAL DIRECTOR J. AHRENS CO 2432		REISTERSTOWN RD 17	

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

JANUARY 1902

REPORT

OF THE

COMMISSIONER

OF THE

LAND OFFICE

FOR THE

YEAR

1901

AND

FOR

THE

YEAR

1902

AND

FOR

THE

YEAR

1903

ALBANY: J.B. LIPPINCOTT & CO.

M-635

50 9096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9096

Registered No.

RTA-141226

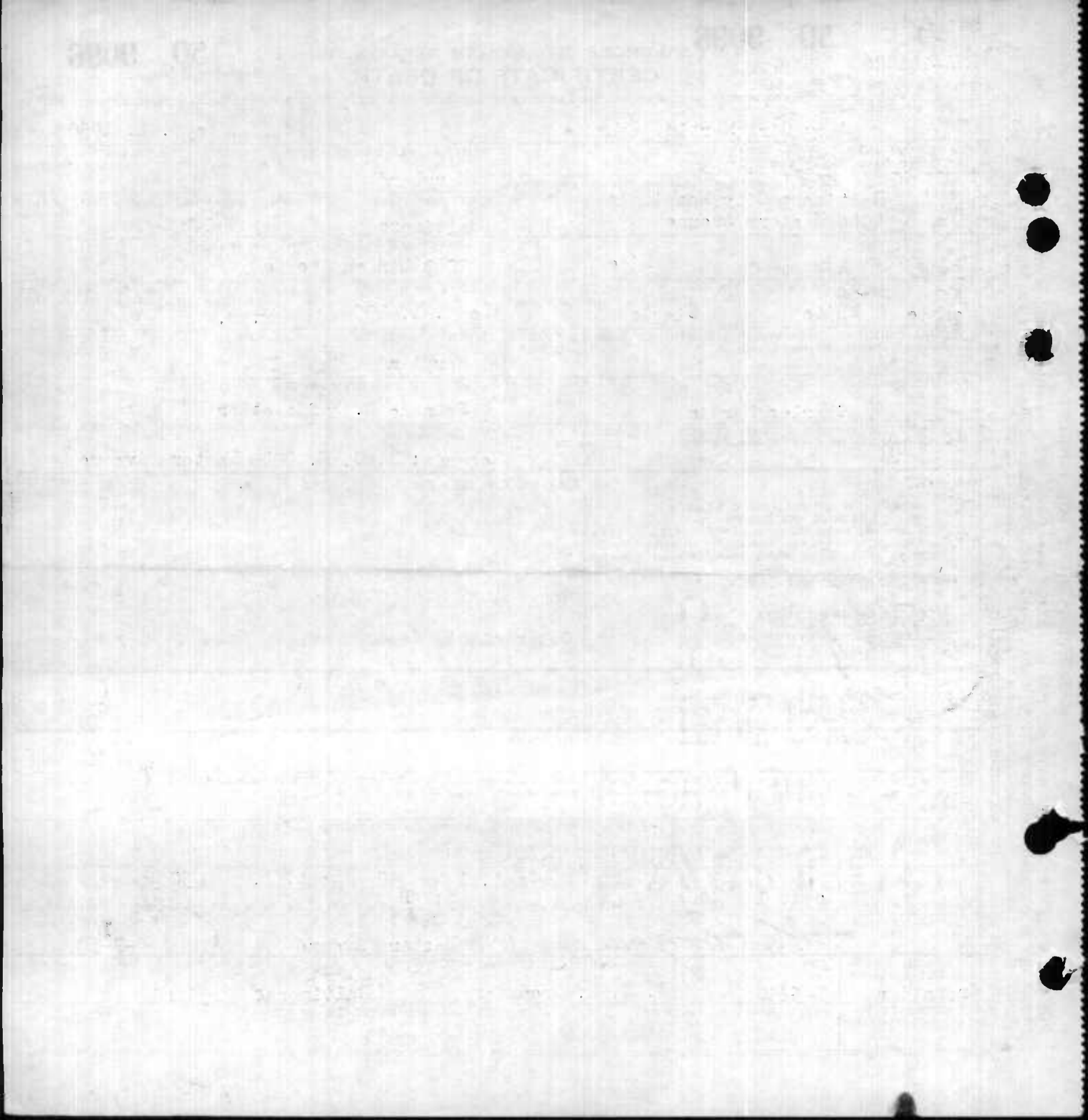
BIRTH NO. 50-19929

1. NAME OF DECEASED (Type or Print) <u>Baby Girl Martin, Johnnie</u>			2. DATE OF DEATH <u>Sept. 1, 1950</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>13-02</u>		
C. Length of stay in Baltimore <u>Life</u> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>2243 Linden Avenue</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 1, 1950</u>		9. AGE (In years last birthday) <u>1-10-00</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Charles Martin</u>			14. MOTHER'S MAIDEN NAME <u>Johnnie E. Huffstetler</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Records: B. C. H. 4940 Eastern Avenue</u>		
18. <u>760.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u> DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Congenital Atelectasis</u> DUE TO _____ <u>Subarachnoid Hemorrhage</u> DUE TO _____ <u>Subtentorial Hemorrhage</u> DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>					
19A. DATE OF OPERATION <u>2</u>			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Sept. 1, 1950</u> , to <u>Sept. 1, 1950</u> , that I last saw the deceased alive on <u>Sept. 1, 1950</u> , and that death occurred at <u>3:25 P. M.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>[Signature]</u> M. D.			23B. ADDRESS <u>4940 Eastern Avenue</u>		23C. DATE SIGNED <u>9-7-50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24B. DATE <u>9-5-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>B. C. H. Crematory</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS

OCT 24 1950

VS 150

160a



M-460

50 9097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9097

Registered No. _____

BIRTH NO.			1. NAME OF DECEASED (Type or Print) DOROTHEA MUELLER			2. DATE OF DEATH Oct. 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____					
B. FULL NAME OF HOSPITAL OR INSTITUTION 508 Normandy Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-01					
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 2815 Jefferson St.					
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 18, 1882		9. AGE (in years last birthday) 68	11 Under 1 Year Months: Days		11 Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME -			14. MOTHER'S MAIDEN NAME Henrietta Busch					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mr Nicholas F. Mueller, Jr. 3228 Clifmont Ave.		

MEDICAL CERTIFICATION	18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage		CAUSE OF DEATH Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 hours	
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO Hypertensive Cardio Vascular		year	
			(B) DUE TO Heart disease			
			(C)			
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from March 1950 to Oct 21, 1950 , that I last saw the deceased alive on 10-21 , 19 50 , and that death occurred at 4 A m., from the causes and on the date stated above.						
23A. SIGNATURE William L. Feenoz		M. D.		23B. ADDRESS 3025 Belair Road		23C. DATE SIGNED 10-23-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/24/50		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.
DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1950		REGISTRAR'S SIGNATURE Washington Williams		25. FUNERAL DIRECTOR Wm J. J. Tucker		ADDRESS Balto, Md.

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]



50 9098

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9098

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE MILLER

2. DATE
OF
DEATH

10/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

5334 Beaufort Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-18

D. STREET ADDRESS (If rural, give location)

5334 Beaufort Avenue

C. Length of stay in Baltimore 33 yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Aug 21, 1891

9. AGE (In years last birthday)

59

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Louis Miller- 3800 Mt. Pleasant Avenue

18. 193X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Brain Tumor

18 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

May 12-50

19B. MAJOR FINDINGS OF OPERATION

Brain Tumor - glioma

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1949 to Oct. 23, 1950 that I last saw the deceased alive on Oct. 23-1950 and that death occurred at 1:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Herman Seidel

23B. ADDRESS

2404 Entaw Pl

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-24-50

24C. NAME OF CEMETERY OR CREMATORY

Workmen Circle Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

Sol. Levinson & Bros. - 1124-26 W. North Ave

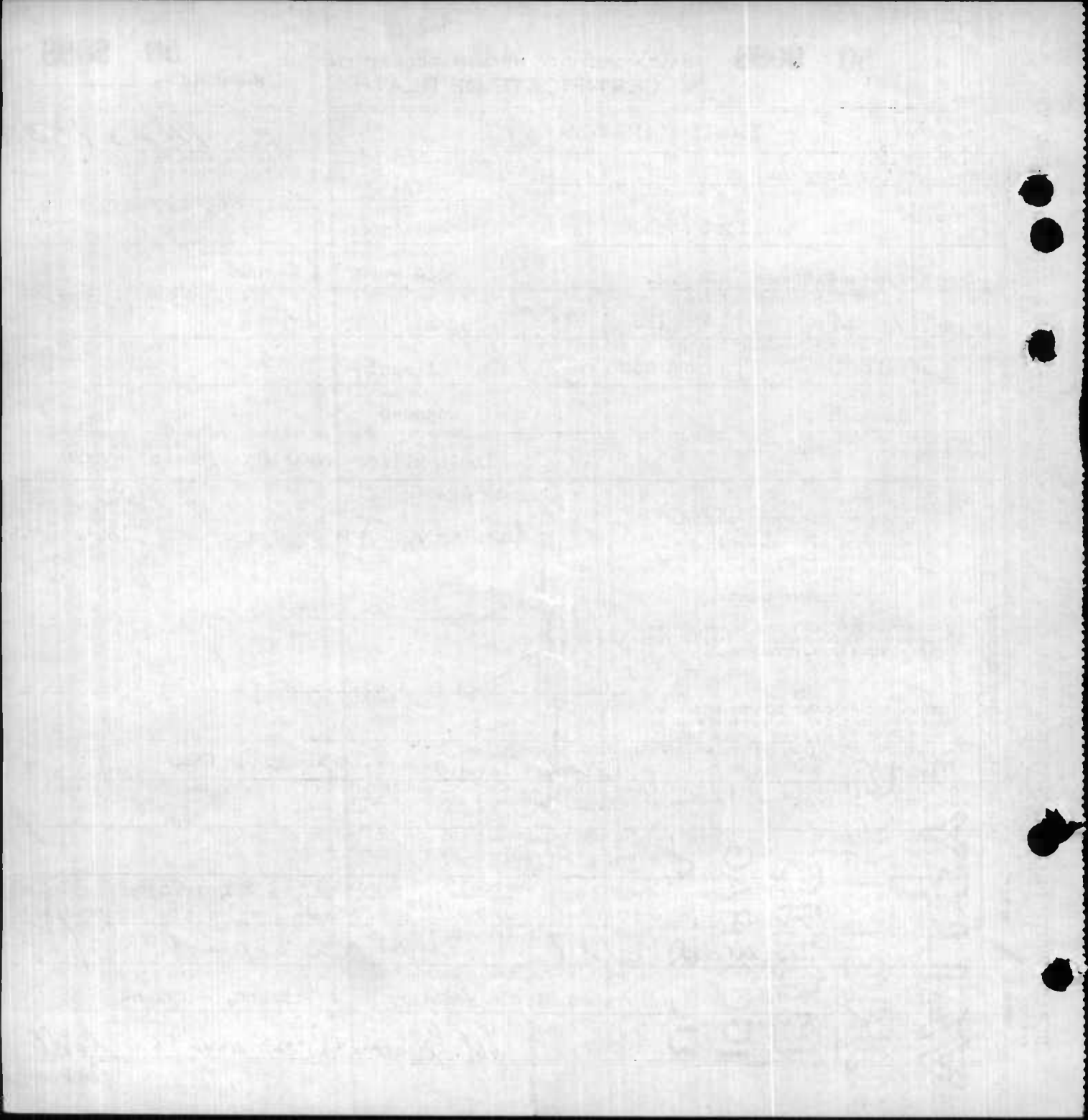
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9099**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)**RAYMOND CONYERS**2. DATE
OF
DEATH**October 22, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
location)**University Hospital**C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)**Baltimore****11-04**

D. STREET ADDRESS (If rural, give location)

321 W. Hoffmann Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

colored7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)**51**If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)**laborer**10B. KIND OF BUSINESS OR
INDUSTRY**R.R. Brake**

11. BIRTHPLACE (State or foreign country)

N. C.12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

W. H. Hines

14. MOTHER'S MAIDEN NAME

Dora15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Walke May Hines

ADDRESS

321 W. Hoffmann St18. **561.5**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) **Intestinal obstruction**DUE TO **internal strangulated hernia of small
intestines**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Ouellette23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Oct. 23, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)**Burial**

24B. DATE

Oct 26-50

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county)

a a co. md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR**OCT 24 1950**

REGISTRAR'S SIGNATURE

Washington Williams

25. FUNERAL DIRECTOR

Jamie Hayes

ADDRESS

638 N. 9th St

CLINT COURT OF DEATH

SECTION ONE OF THE COURT OF DEATH

CLINT COURT OF DEATH

SECTION ONE OF THE COURT OF DEATH

SECTION ONE OF THE COURT OF DEATH

M-32050 9100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9100

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Sarah Ann Matthews			2. DATE OF DEATH Oct. 22, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 41 E. Montgomery St			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION 00			C. CITY OR TOWN (If outside corporate limits, give township) Baltimore		
c. Length of stay in Baltimore 70 years			D. STREET ADDRESS (If rural, give location) 41 E. Montgomery St		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 18, 1884		9. AGE (In years, last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John W. Walker			14. MOTHER'S MAIDEN NAME Eliza Hickman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Marjorie Matthews, 41 E. Montgomery	

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Bronchial Pneumonia DUE TO (B) Generalized Arterio Sclerotic Cardiovascular Disease DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH vda 10 yrs
---	--	--	--	---

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/9 , 19 40 , to 10/22 , 19 50 , that I last saw the deceased alive on 10/22 , 19 50 and that death occurred at 5P m., from the causes and on the date stated above.					
23A. SIGNATURE Joseph S. Laukaitis		23B. ADDRESS 679 Washington Blvd		23C. DATE SIGNED 10/23/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 10-26-50	24C. NAME OF CEMETERY OR CREMATORY Western		24D. LOCATION (City, town, or county) (State) Baltimore City	
DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1950		REGISTRAR'S SIGNATURE William H. Hubbard		25. FUNERAL DIRECTOR Howard H. Hubbard, 2503 Edmondson Ave	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1500
1600
1600

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text at the bottom of the page, including the number 42 and other illegible markings.

MARGIN RESERVED FOR INDEXING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9101

BALTIMORE CITY HEALTH DEPARTMENT

50 9101

Registered No.

BIRTH NO. GEORGE HERMAN ROSENTHAL **CERTIFICATE OF DEATH**

1. NAME OF DECEASED (Type or Print) GEORGE HERMAN ROSENTHAL 2. DATE OF DEATH 10-23-50

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION Sumner 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-18

7. STREET ADDRESS (If rural, give location) 3703 Beecher Ave 8. DATE OF BIRTH 9. AGE (In years last birthday) 37 10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

c. Length of stay in Baltimore Life 12. SEX Male 13. COLOR OR RACE White 14. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

15a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker 15b. KIND OF BUSINESS OR INDUSTRY 16. DATE OF BIRTH Baltimore Md 17. CITIZEN OF WHAT COUNTRY?

18. FATHER'S NAME Isaac 19. MOTHER'S MAIDEN NAME Kadlune

20. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 21. SOCIAL SECURITY NO. 22. INFORMANT Rae Rosenthal ADDRESS Same

23. 18. 470.0 CAUSE OF DEATH. INTERVAL BETWEEN ONSET AND DEATH

24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction

25. ANTECEDENT CAUSES DUE TO (A) H A S H D

26. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)

27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)

28. 19A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

29. 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

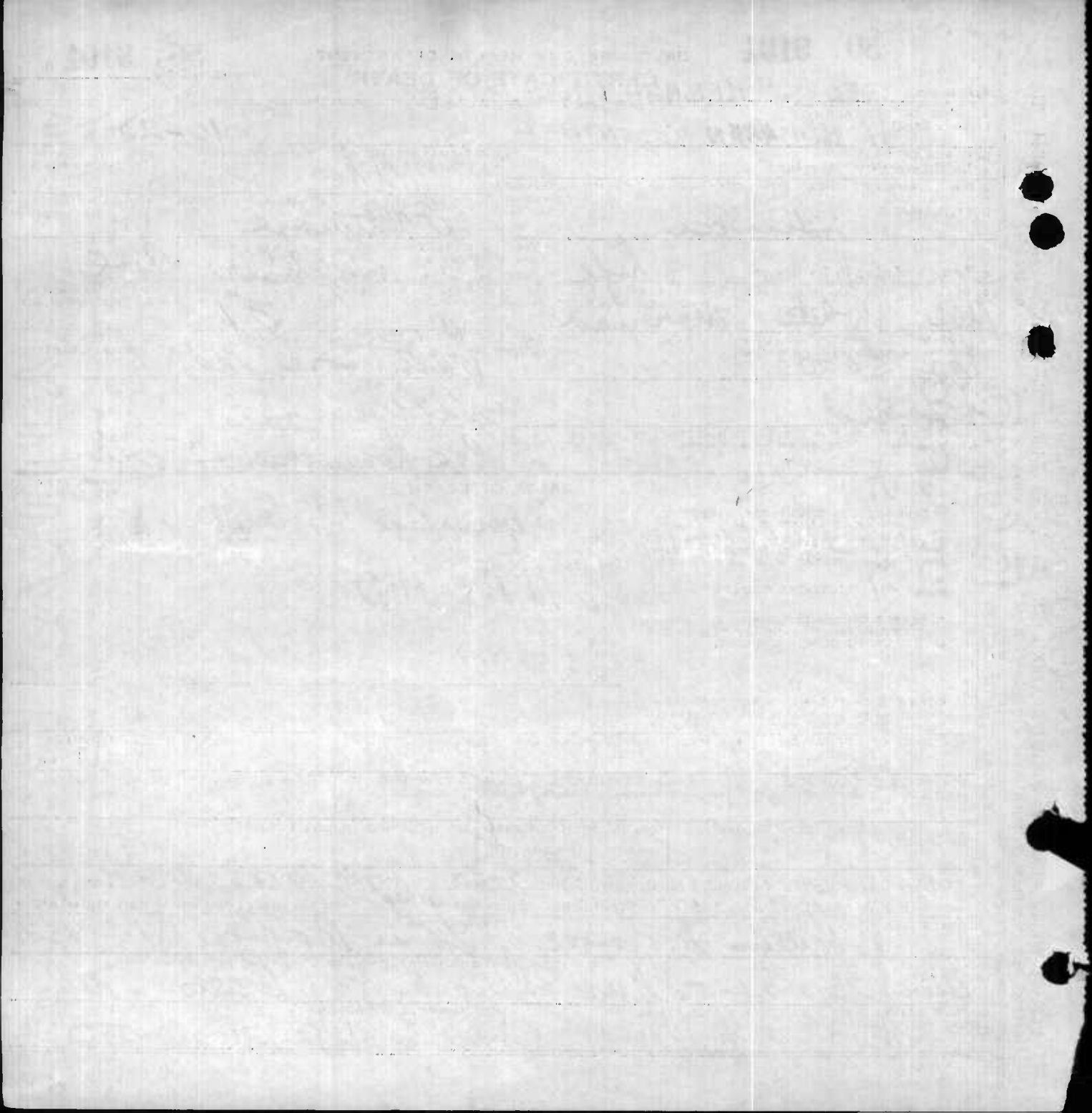
30. 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK 21F. HOW DID INJURY OCCUR?

31. 22. I hereby certify that I attended the deceased from 9-23, 1950, to 10-23, 1950, that I last saw the deceased alive on 10-23, 1950, and that death occurred at 4:30 p. m., from the causes and on the date stated above.

32. 23A. SIGNATURE William M. Bange 23B. ADDRESS Sumner Hospital 23C. DATE SIGNED 10-23-50

33. 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 10-24-50 24C. NAME OF CEMETERY OR CREMATORY B'nai Israel 24D. LOCATION (City, town, or county) (State) Balto Md

34. DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1950 35. REGISTRAR'S SIGNATURE Washington Williams, Md 36. FUNERAL DIRECTOR Jack Lewicki ADDRESS 2100 Centaw Pl



512
50 9102BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9102
Registered No.

BIRTH NO.		50 9102	
1. NAME OF DECEASED (Type or Print) <i>Vincent Dembowski</i>		2. DATE OF DEATH <i>Oct 22 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>1630 Benhill Ave</i> B. COUNTY <i>Maryland</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>A Balto General</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>1630 Benhill Ave 25-05</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 20, 1912</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>U.S. Coast Guard</i>	9. AGE (In years last birthday) <i>38</i>
13. FATHER'S NAME <i>John Dembowski</i>		14. MOTHER'S MAIDEN NAME <i>Don't know</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Rose B. Dembowski</i>		ADDRESS <i>1630 Benhill Ave</i>	
18. <i>E812.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Skull Fracture</i> (A) <i>Skull Fracture</i> DUE TO <i>Subdural Hemorrhage</i> (B) <i>Subdural Hemorrhage</i> DUE TO <i>Compound Comminuted Fracture of Left Tibia & Fibula</i> (C) <i>Compound Comminuted Fracture of Left Tibia & Fibula</i>			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Street</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Benhill and Pennington Ave.</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Oct. 22, 1950 12:05 A.m.</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <i>Pedestrian struck by auto</i>		22. I certify that I took charge of the remains described above, held an <i>Autopsy</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .	
23A. SIGNATURE <i>William V. Lewis</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. <i>10-22-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 25 1950</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>		24D. LOCATION (City, town, or county) (State) <i>A. A. Co.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 24 1950</i>		REGISTRAR'S SIGNATURE <i>William V. Lewis</i>	
25. FUNERAL DIRECTOR <i>A. J. ...</i>		ADDRESS <i>14 ...</i>	

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UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF MEDICAL SERVICE
WASHINGTON, D. C.

30 8102



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9103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50

9103

BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
SADIE BELL HAWKINS		20 OCT 50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Good Samaritan Hosp. 27 N. Carey St		Maryland Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location)	
		Baltimore 16-02 822 Woodyear St.	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	Colored	Widowed	Nov-10-1897
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Domestic		PRIVATE none	52 53
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
		none	
17. INFORMANT		ADDRESS	
Maggie Johnson		525 W Biddle St.	
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH
(A) Carcinoma of the breast; DUE TO with metastases			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
(B)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
(C)			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9 Oct, 1950, to 20 Oct, 1950, that I last saw the deceased alive on 20 Oct, 1950, and that death occurred at 6 ⁴⁵ P. m., from the causes and on the date stated above.			
23A. SIGNATURE		23B. ADDRESS	23C. DATE SIGNED
Emil H. Henning Jr. M. D.		601 W. Indiana Way	20 Oct 50
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
RURAL	10-14-1950	Grav Auburn	Balto. Ind
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS	
OCT 24 1950	Thurston Williams	Charles A. Alexander 1200 McCallah street	

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OFFICE OF THE

50 9104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9104

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KINZIE

W.

TAYLOR

2. DATE

OF DEATH Oct. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION
Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

12-05

D. STREET ADDRESS (If rural, give location)

Basement Apt.

1618 N. Calvert St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1880

9. AGE (In years

last birthday)

70

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Hospital Attendant

11. BIRTHPLACE (State or foreign country)

N. Car.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mabel E. Murphy

1618 N. Calvert St

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia and myocardial insufficiency

DUE TO arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

B. S. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒ASSISTANT MEDICAL EXAMINER.....☐

23C. DATE SIGNED

Oct. 19, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 24, 50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Cook, Jr.

25. FUNERAL DIRECTOR

William Cook, Jr.

ADDRESS

1217 St. Paul Street

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M-460

50 9105

BALTIMORE CITY HEALTH DEPARTMENT

50 9105

Registered No.

CERTIFICATE OF DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mollie Ricard Miller</i>		2. DATE OF DEATH <i>Oct. 22, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1400 N. Lexington St.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Aged Women's and Aged Men's Homes</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 19-02</i>			
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1400 N. Lexington Street</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Sept. 24, 1865</i>	9. AGE (In years last birthday) <i>85</i>	10. Under 1 Year Months: Days <i>- 28</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Never employed.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Thomas H. H. Miller</i>		14. MOTHER'S MAIDEN NAME <i>Martha M. Rigby</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>L. H. Read, 1400 N. Lexington St.</i>	
18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Central Neurology</i> DUE TO (B) <i>Arteriosclerosis Cerebro-Vascular</i> DUE TO <i>disease</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>January 1, 1949</i> , to <i>October 22, 1950</i> , that I last saw the deceased alive on <i>October 22, 1950</i> and that death occurred at <i>6:30 P. M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Wendell Edward Day</i>		23B. ADDRESS <i>4-E-33rd St Balto 18</i>		23C. DATE SIGNED <i>Oct 23, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/24-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25. FUNERAL DIRECTOR <i>W. H. Cook Inc.</i>		ADDRESS <i>1317 S Y Paul St</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 24 1950</i>		REGISTRAR'S SIGNATURE <i>Wendell Edward Day</i>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint, illegible handwriting visible through the paper]

M-420

50 9106

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9106

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

CHRISTOPHER T. MILKE

2. DATE
OF
DEATH

10-22-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

BALTIMORE 20-04

c. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

2507 Hollins St.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

August 22, 1903

9. AGE (In years,
last birthday)

47

10 Under 1 Year
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

MACHINIST

10b. KIND OF BUSINESS OR
INDUSTRY

Gas & Electric

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS K. MILKE

14. MOTHER'S MAIDEN NAME

MARY BRENNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, or no known) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL
SECURITY NO.

212-05-7092

17. INFORMANT

ADDRESS

HELEN MILKE 2507 Hollins St.

18. 42011

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) ACUTE PULMONARY EDEMA

10 MINUTES

DUE TO

ANTECEDENT CAUSES

(B) CORONARY THROMBOSIS

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 10-22, 1950, to 10-22, 1950, that I last saw the
deceased alive on 10-22, 1950, and that death occurred at 3:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE

Edward M. Rehake

M. D.

23b. ADDRESS

Bon Secours Hospital

23c. DATE SIGNED

10-22-50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24b. DATE

10-25-50

24c. NAME OF CEMETERY OR CREMATORY

LORRAINE PARK

24d. LOCATION (City, town, or county)

BALTO. County, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

544 SE

094a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

STATE OF TEXAS

Blank lined area for text entry.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9107

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET Mary Peddy

2. DATE
OF
DEATH

October 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
MarylandB. COUNTY
BaltimoreB. FULL NAME OF
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson

c. Length of stay in Baltimore

33

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

644 N. Charles Street Avenue

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 30, 1917

9. AGE (In years
last birthday)

33

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert J. Doyle

14. MOTHER'S MAIDEN NAME

Marie Steele

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Thomas E. Peddy-644 N. Charles St.

18. 330 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Subarachnoid hemorrhage due to
ruptured aneurysm of left vertebral
artery

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Henry K. Ourlacher M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

10-23-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county) (State)

Balto. Co.,

Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 24 1950

REGISTRAR'S SIGNATURE

W. Williams, Jr.

25. FUNERAL DIRECTOR

Henry W. Jenkins & Sons Co.

ADDRESS

4905 York Rd.

Balto. 12, Md.

VS 151

0832

CERTIFICATE OF DEATH

BALTIMORE CITY DEPARTMENT OF HEALTH

50 8107

50 8107

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

50 9108

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9108

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Manns

2. DATE
OF
DEATH Oct. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 7531 Harford Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 27-05

D. STREET ADDRESS (If rural, give location)

7531 Harford Road

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 19, 1865

9. AGE (In years
last birthday)

85

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Seed merchant

10B. KIND OF BUSINESS OR
INDUSTRY

Seeds

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Herbert Neuman 7531 Harford Road

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

1 month
8 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-

DUE TO

(C) vascular disease

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/12, 1950, to 10/21, 1950, that I last saw the deceased alive on 10/21, 1950, and that death occurred at 6 P. M., from the causes and on the date stated above.

23. SIGNATURE

Michael L. Phinney

M. D.

23B. ADDRESS

116 Chase St.

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

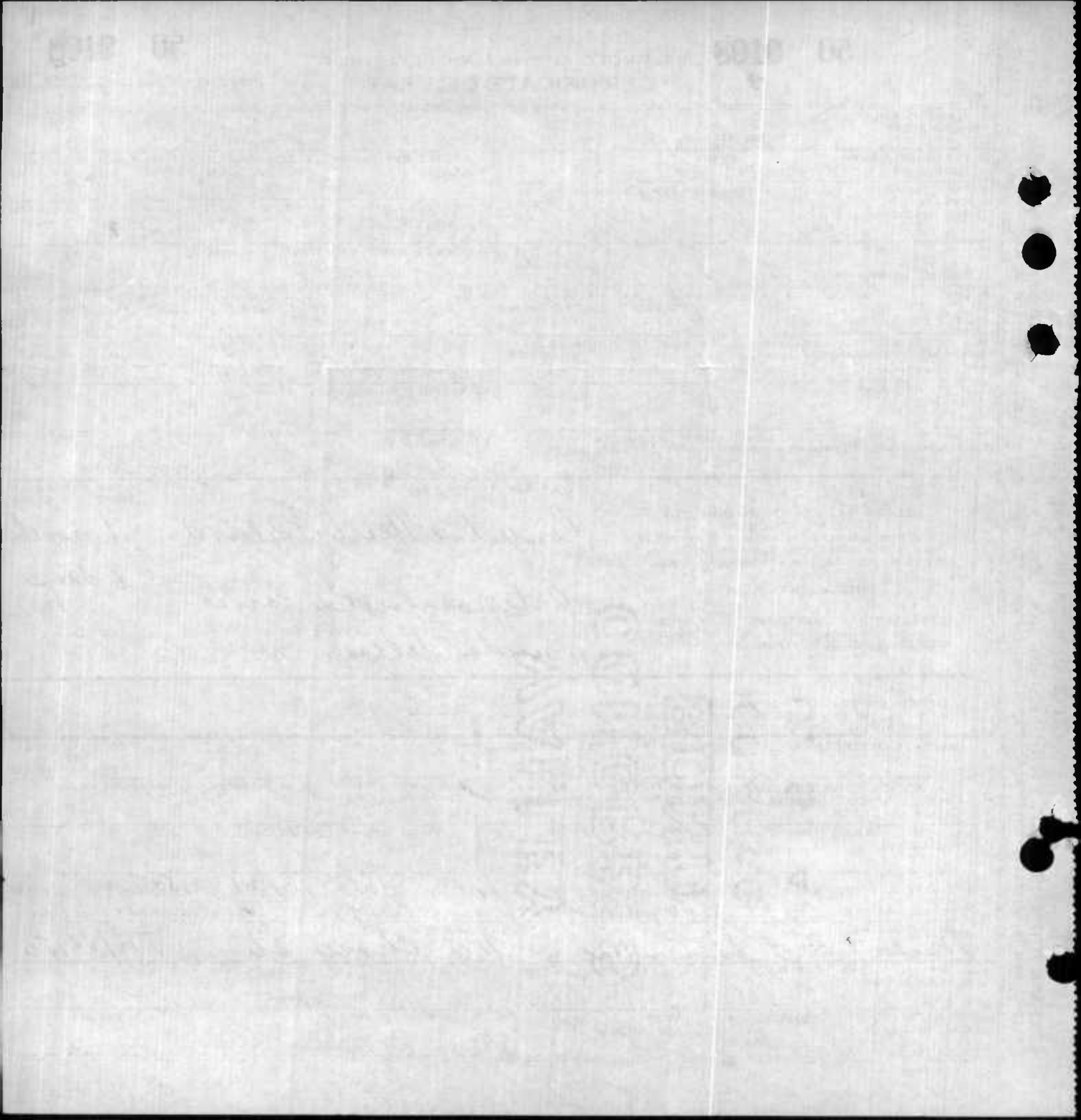
REGISTRAR'S SIGNATURE

Eustace Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ulrich Funeral Home 2008 Orleans St.



50 9109

50 9109

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. 50-21902

1. NAME OF DECEASED (Type or Print) <u>BABY MARTIN JASKULSKI</u>			2. DATE OF DEATH <u>10-22-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 8-06</u>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>1613 N Chapel St</u>		
5. SEX <u>m.</u>	6. COLOR OR RACE <u>w.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>3</u>	8. DATE OF BIRTH <u>10/13/50</u>	9. AGE (In years last birthday) <u>9</u>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>		12. CITIZEN OF WHAT COUNTRY? <u>✓</u>
13. FATHER'S NAME <u>Carroll G. Jaskulski</u>			14. MOTHER'S MAIDEN NAME <u>Rosina M. Porecki</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Carroll G. Jaskulski, 1613 Chapel St</u>		

18. <u>756.2</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <u>Bronchopneumonia, bilateral</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) <u>Aspiration</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <u>Congenital malrotation of Cecum</u> <u>Obstruction of Duodenum</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>22 hours</u>			
19A. DATE OF OPERATION <u>10-20-50</u>	19B. MAJOR FINDINGS OF OPERATION <u>Malrotation of Bowel, Duodenal Obstruction</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-13-50</u> to <u>10-22-50</u> that I last saw the deceased alive on <u>10-22-50</u> , and that death occurred at <u>5:30</u> p.m., from the causes and on the date stated above.			
23A. SIGNATURE <u>Judith B. Leland</u> M.D.		23B. ADDRESS <u>Sinai Hospital Baltimore</u>	23C. DATE SIGNED <u>10-22-50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Crema</u>	24B. DATE <u>10/24/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore md</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT 24 1950</u>	REGISTRAR'S SIGNATURE <u>Thurston Williams</u>	25. FUNERAL DIRECTOR ADDRESS <u>Blanche F. Hoffman 1639 Broadway</u>	

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be completely supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

0018

06

0018

06

RECEIVED

RECEIVED

50 9110

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9110
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Yeagley, Mrs. Daisy M.

2. DATE
OF
DEATH

Oct. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

8-07

D. STREET ADDRESS (If rural, give location)

1821 E. Biddle St

c. Length of stay in Baltimore

60 Years

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 17, 1876

9. AGE (In years
last birthday)

74

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

PA.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Frey

14. MOTHER'S MAIDEN NAME

Sarah Shenberty

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 322X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Thrombosis

6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypostatic Pneumonia

2 days

DUE TO

(C) Generalized Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/18, 1950, to 10/23, 1950, that I last saw the
deceased alive on 10/22, 1950, and that death occurred at 12:05 A.m., from the causes and on the date stated above.

23A. SIGNATURE

N. Reed Carroll

M. D.

23B. ADDRESS

Church Home of Hospital

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/26/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 24 1950

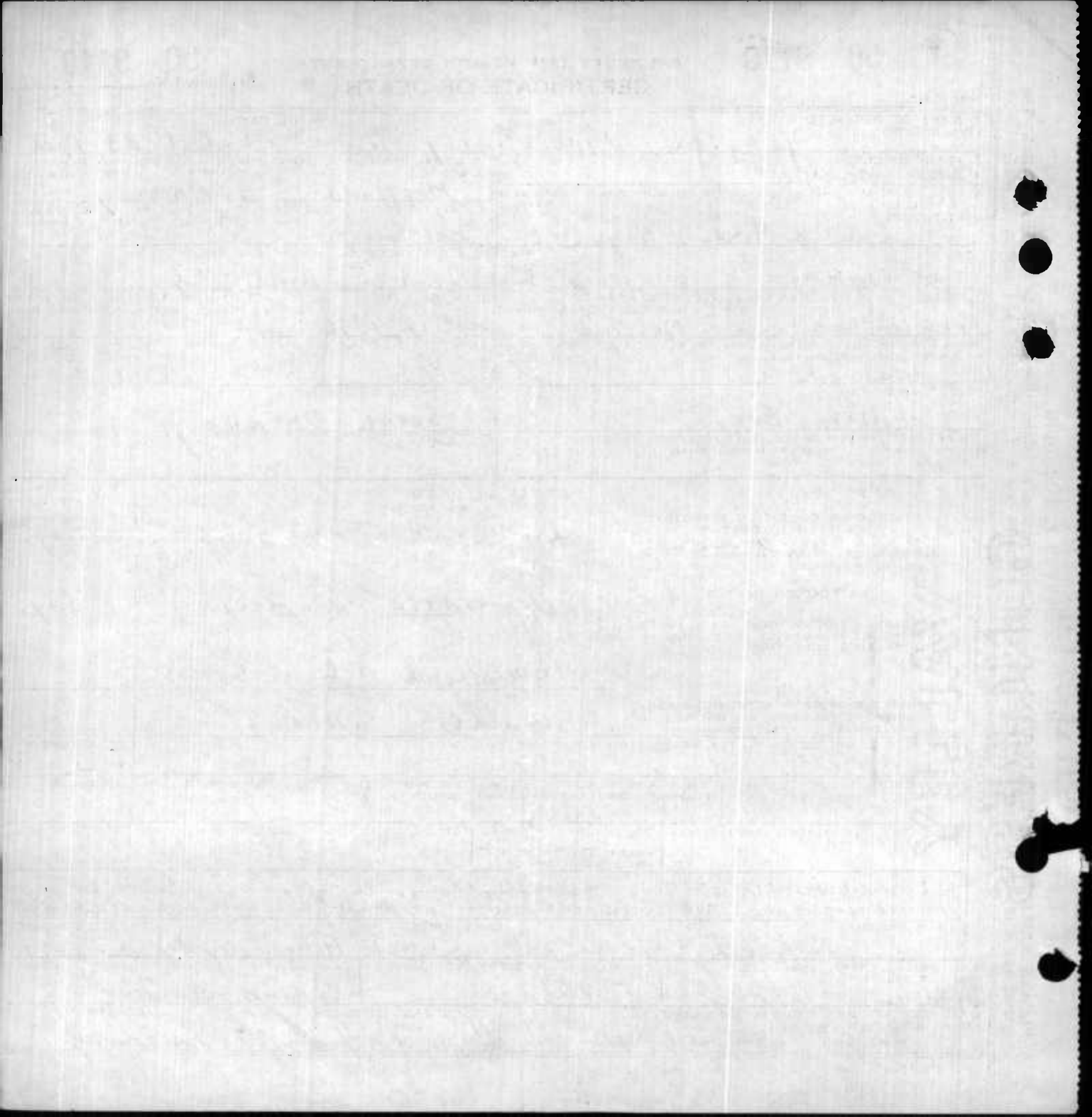
REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

Harold F. Hoffmann 1639 Broadway

ADDRESS



1112 03

1112 03

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

B-500

50 9112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9112

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Harrison Boone

2. DATE
OF
DEATH

Oct. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1709 Brentwood ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore 12-05

D. STREET ADDRESS (If rural, give location)

1709 Brentwood ave

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS - the St.

18. 023X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Syphilitic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) with Aortic Insufficiency

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

10-22-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 151

97024

0302 ✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9113

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9113

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Katherine D. Lake

2. DATE
OF
DEATH

Oct. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

2409 Annapolis Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore 25-33 township)

D. STREET ADDRESS (If rural, give location)

2409 Annapolis Road

c. Length of stay in Baltimore

86 Years

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 1, 1853

9. AGE (In years
and birthday)

97

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin Many

14. MOTHER'S MAIDEN NAME

Martha ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

none

17. INFORMANT 2409 Annapolis Road
Mr. Mynard Lake ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Arteriosclerotic Cordis vascular?
disease.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 25, 1947, to Oct 23, 1950, that I last saw the
deceased alive on Oct 23, 1950, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Carol Proctor

M. D.

23B. ADDRESS

1326 W Lombard St

23C. DATE SIGNED

Oct 23, 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 26, 1950

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

24D. LOCATION (City, town, or county)

Woodlawn Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Miller MD

25. FUNERAL DIRECTOR

Henry Sander & Sons Inc.
Baltimore Md.

ADDRESS

OCT 24 1950

VS 150

093d

3113 20

THE OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

3113 20

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal document, possibly a certificate or a report, with several paragraphs of text and a signature line at the bottom.]

[Signature]

[Faint text at the bottom of the page, possibly a date or reference number.]

BIRTH NO.

50 9114

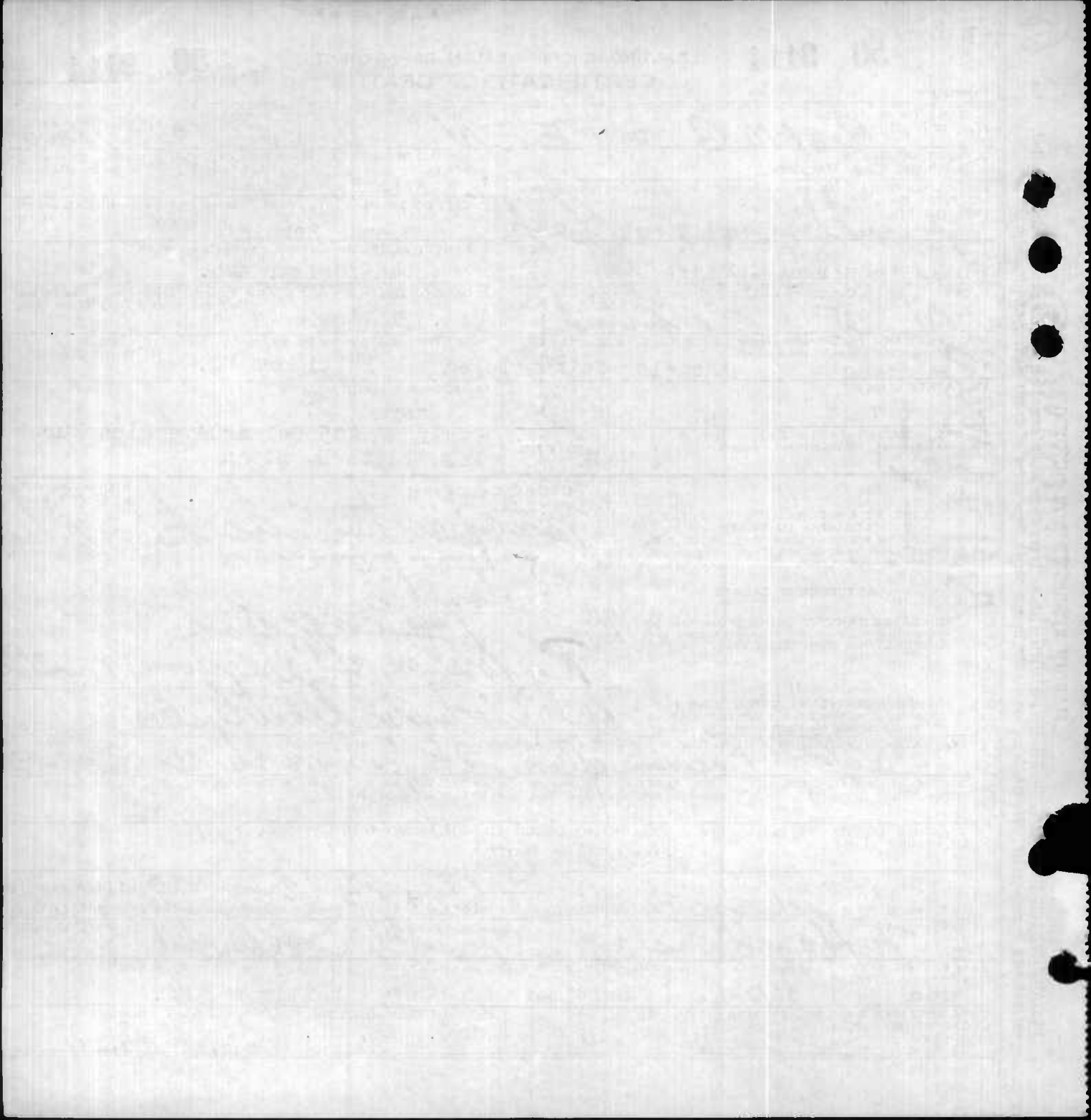
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9114

1. NAME OF DECEASED (Type or Print) HIRAM G. STEEN			2. DATE OF DEATH 10/21/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE Maryland B. COUNTY Anne Arundel		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Franklin Square Hosp.			C. CITY OR TOWN Glenn Bernie		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 405 Delmar Ave. 5200		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 5, 1873		9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Jeweler Selfempl	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ? Steen			14. MOTHER'S MAIDEN NAME Mary ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT 405 Delmar Ave Glenn Bernie Mrs. Edith E. Steen ADDRESS		

MEDICAL CERTIFICATION

18. 153X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Postoperative Shock DUE TO Peritonitis DUE TO off Cecum Perforation of Cecum Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 24 hrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 10/20/50	19B. MAJOR FINDINGS OF OPERATION Carcinoma of Cecum & Perforation & shock	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 9/17, 1950 to 10/22, 1950 that I last saw the deceased alive on 10/22, 1950 , and that death occurred at 11:55 PM from the causes and on the date stated above.		
23A. SIGNATURE G. F. Hawker, Jr. M.D.	23B. ADDRESS Franklin Square Hosp.	23C. DATE SIGNED 10/22/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/24/50	24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. NAME AND ADDRESS OF SONS, INC. BALTO., 13, MD.
DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1950		REGISTRAR'S SIGNATURE Washington Williams



50 9115 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9115
 Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
 (Type or Print) *Germy Scott*

2. DATE OF DEATH *October 20, 1950*
 (Where deceased lived, If institution: residence before admission)

3. PLACE OF DEATH:
 A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
 A. STATE *md.* B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION
JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 10-02

D. STREET ADDRESS (If rural, give location)
716 N. Eden St.

c. Length of stay in Baltimore

Yrs.
 Mos.
 Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

5-8-95

9. AGE (in years last birthday)

55

If Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer (unemployed) ODD JOBS

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George Scott

14. MOTHER'S MAIDEN NAME

Mynick Knox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

yes would have

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
JOHNS HOPKINS HOSPITAL

18. *446X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *uremia*

2 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *arteriosclerotic nephritis*

?

DUE TO

(C)

II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
 YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *9-26*, 1950, to *10-20*, 1950, that I last saw the deceased alive on *10-20*, 1950, and that death occurred at *10:20 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Victor G. McKusick

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct 25/50

24C. NAME OF CEMETERY OR CREMATORY

Bald National Cem.

24D. LOCATION (City, town, or county)

Bald, Md.

DATE RECEIVED BY LOCAL REGISTRAR

OCT 24 1950

REGISTRAR'S SIGNATURE

Victor G. McKusick

25. FUNERAL DIRECTOR

Mrs. Robert G. Elliott Daughter

ADDRESS

*1124 N. Caroline St
 131a*

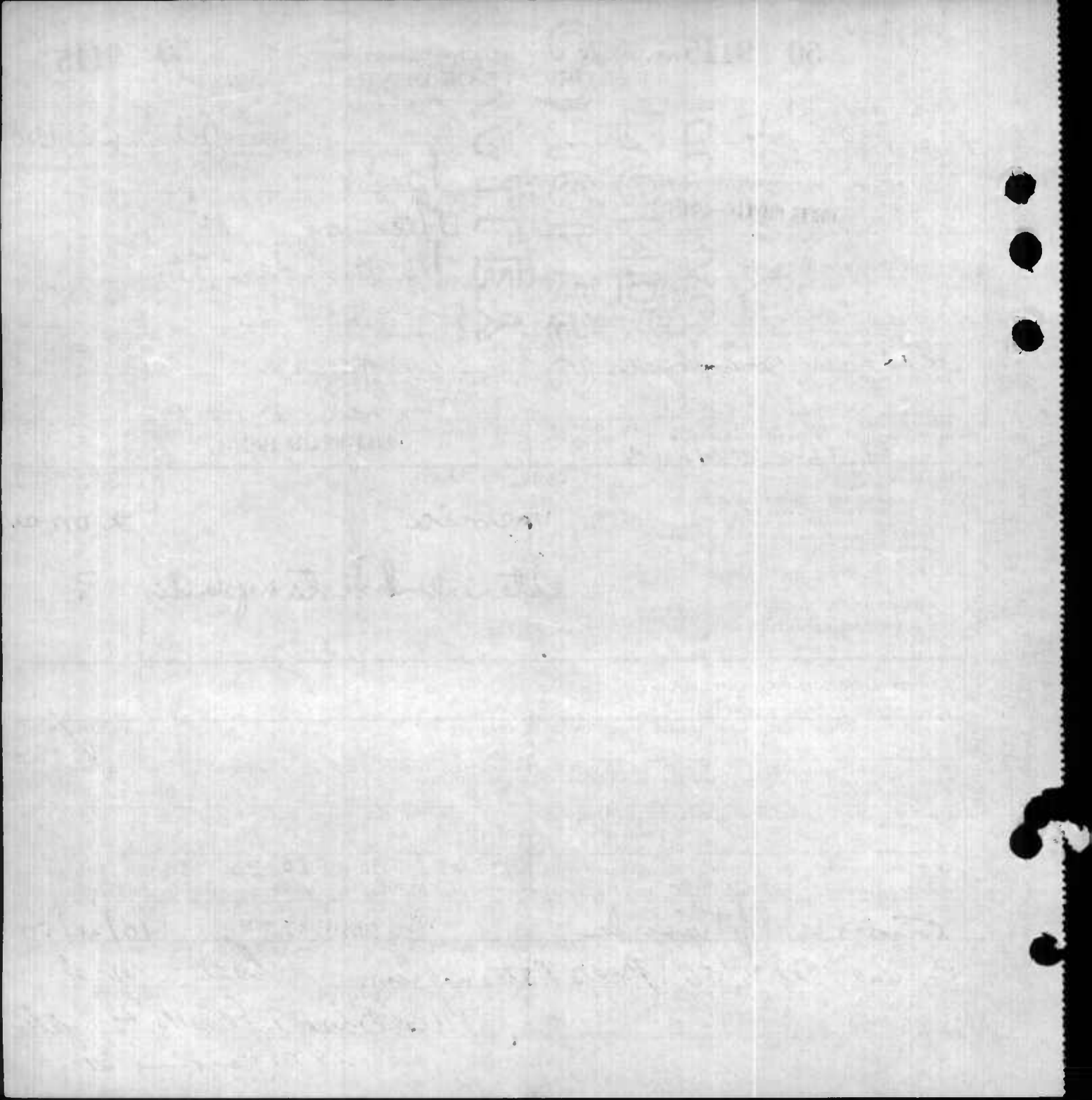
VS 150

(Victor G. McKusick)

97099

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9116

Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) Ruth Neal

2. DATE
OF
DEATH

Oct. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1326 N. Calhoun St.

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

1326 N. Calhoun St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

Nov. 17, 1887

9. AGE (in years
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Alexander Stewart

14. MOTHER'S MAIDEN NAME

Mary Middleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

James Neal 1326 N. Calhoun St.

18. 442X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

2 da

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

no

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/16/50, to 10-22, 1950, that I last saw the
deceased alive on 10/21-1950 and that death occurred at 8 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/25/50

24C. NAME OF CEMETERY OR CREMATORY

St Peters

24D. LOCATION (City, town, or county)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 24 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Geo. G. Nelson 1303 Presstman St.

Geo. G. Nelson

1312

3110 DE

3110 DE

Joseph Landa
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9117

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LANDA

JOSEPH

2. DATE
OF
DEATH

22 Oct. 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if in institution, residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Church Home & H. Sp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

2 East

c. Length of stay in Baltimore

45

D. STREET ADDRESS (If rural, give location)

318 Towson Ave. 5300

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 24, 1875

9. AGE (In years
last birthday)

74

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, or if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Schluderger, Kurdie Co

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Kohn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Landa, Mrs. Theresa

ADDRESS

Balto, Md
318 Towson Ave

18. 177x

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Carcinoma of

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Prostate c

DUE TO

(C)

Metastases

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Oct. 50, 1950, to 22 Oct., 1950, that I last saw the
deceased alive on 22 Oct., 1950, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE

Donald Skelton

M. D.

23b. ADDRESS

Church Home & H. Sp.

23c. DATE SIGNED

22 Oct 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

3310 Taylor Ave., Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

Oct 24 1950

REGISTRAR'S SIGNATURE

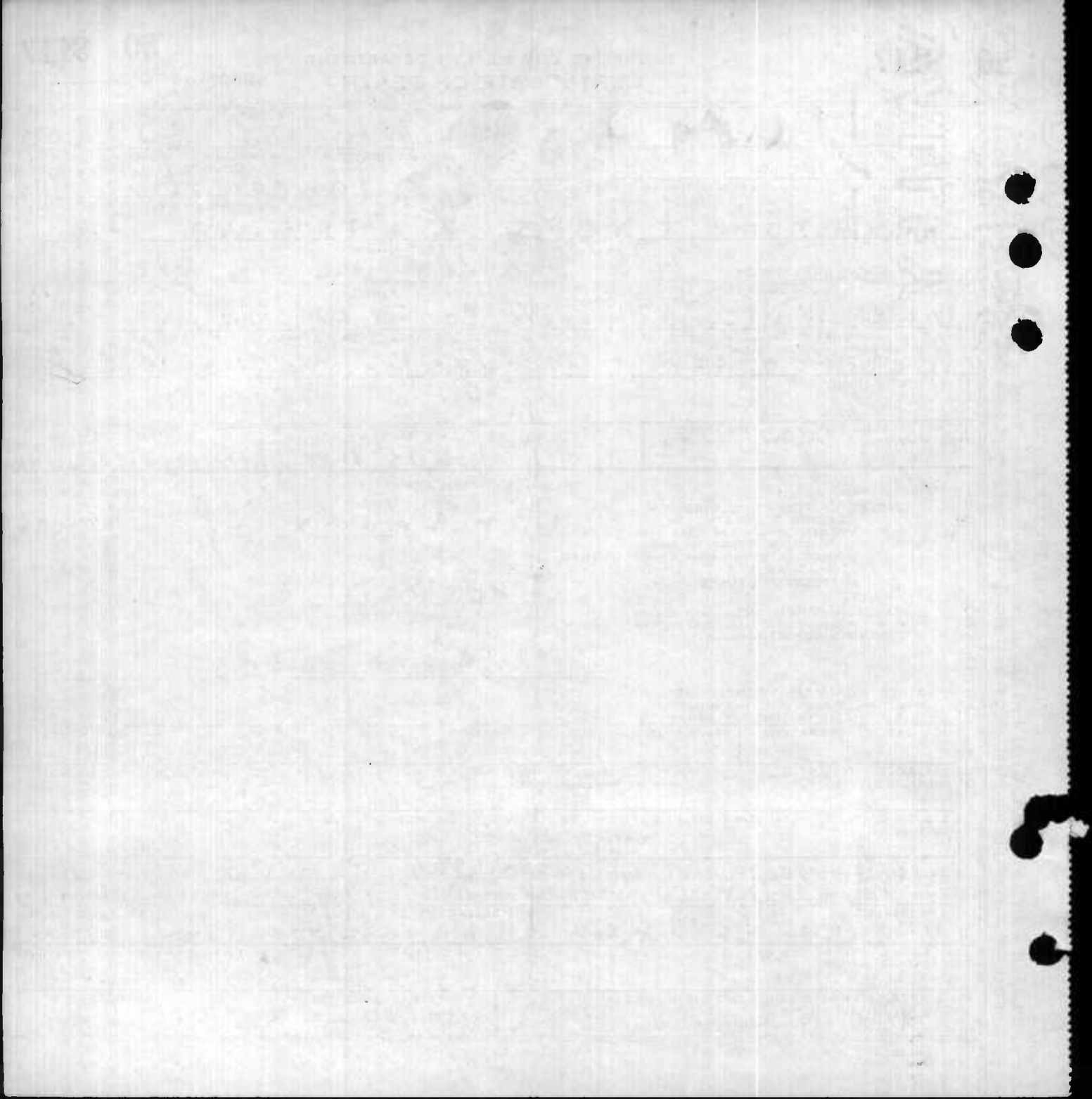
Huntington Williams

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601-3-5 E. Madison St.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9118**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Wilhelmina Agnes Kelly*2. DATE
OF
DEATH*Oct 23/1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *2800 Suffolk Ave*

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2800 Suffolk Ave

C. Length of stay in Baltimore

34 Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

*Female**White**Widow**May 5/1868**82*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

*Housewife**Richmond Va*

13. FATHER'S NAME

Jacob Schwartz

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Phil Richard J. Burke 2800 Suffolk Ave*18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ...

DUE TO

*Myocardial Infarct**1 day*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...

DUE TO

*Marked General Atherosclerosis**7*

(C) ...

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from *Sept*, 1950, to *Oct 23*, 1950, that I last saw the deceased alive on *107 23*, 1950, and that death occurred at *11:15 PM*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Wenard P. Pagan**33 N. Frederick St**107 23/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Oct 24 1950**Wenard P. Pagan**Wenard Pagan 4611 Park Heights*

2110

02

PAGE 10

2110

02



MARGIN RESERVED FOR BINDING

PLEASE WRITE IN PENCIL, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 9119**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)**ETHEL JOHNSON**2. DATE
OF
DEATH**OCT 23, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore**12-07**

D. STREET ADDRESS (If rural, give location)

113 W. 25th Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

MAY 25, 1902

9. AGE (in years last birthday)

48

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CLERK - DRY CLEANING STORE

10B. KIND OF BUSINESS OR INDUSTRY

ANDERSON CLEANERS

11. BIRTHPLACE (State or foreign country)

Mass.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm. L. Gay

14. MOTHER'S MAIDEN NAME

Almira Emerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-12-0479

17. INFORMANT

ADDRESS

Charlie W. Johnson, 113 W. 25th St.18. **443X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Subarachnoid hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

10 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertensive cardiovascular disease**3 years**

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **OCT 23, 1950** to **OCT 23, 1950** that I last saw the deceased alive on **OCT 23, 1950** and that death occurred at **6:00 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

Elmer W. Demaree, M.D.

23B. ADDRESS

University Hosp

23C. DATE SIGNED

10-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/26/50

24C. NAME OF CEMETERY OR CREMATORY

U. S. National

24D. LOCATION (City, town, or county)

Baltimore, MD

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 24 1950

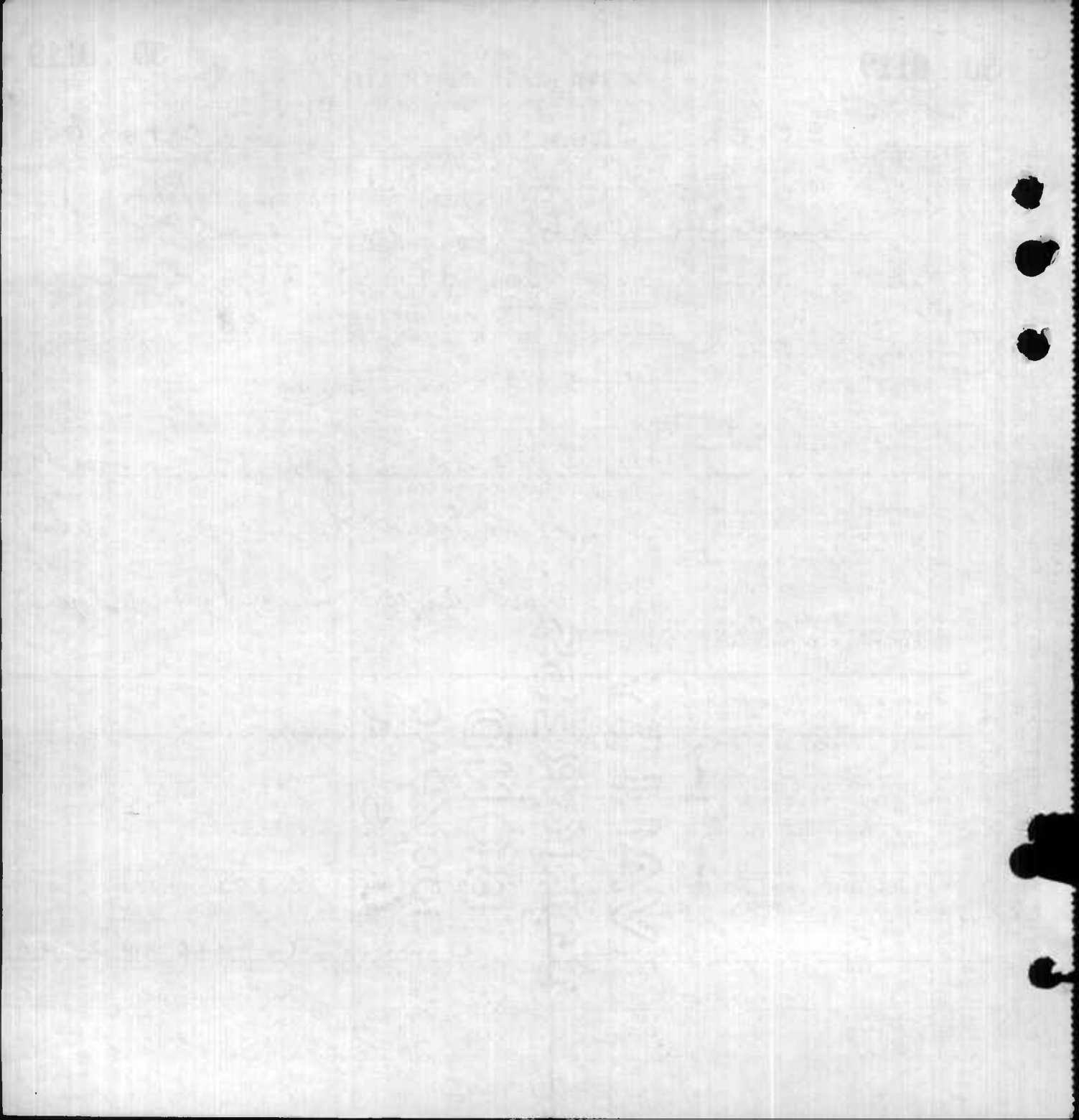
REGISTRAR'S SIGNATURE

Wm. C. Cook, Inc.

25. FUNERAL DIRECTOR

ADDRESS

Wm. C. Cook, Inc., 1217 St. Paul Street



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9120
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

KOSTONTINO

ERIMETIS

2. DATE OF DEATH
October 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
M Pennsylvania

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Philadelphia

D. STREET ADDRESS (If rural, give location)

925 Spruce Street

c. Length of stay in Baltimore

1

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 6, 1884

9. AGE (In years last birthday)

66

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fireman - Watertender

10B. KIND OF BUSINESS OR INDUSTRY

U. S. Merchant Mar.

11. BIRTHPLACE (State or foreign country)

Turkey

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Erimetis

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

None

17. INFORMANT

John Koutovides

ADDRESS

Phila. Pa. 222 So. 50th St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley S. Dureacher M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED
10-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

Oct. 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Philadelphia

24D. LOCATION (City, town, or county)

Philadelphia, Penna.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 24 1950

REGISTRAR'S SIGNATURE

William H. ...

25. FUNERAL DIRECTOR

ADDRESS

William H. ... 1217 St. Paul Street

VS 151

680 55

094a

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be fully and correctly applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M 2200
50 9121

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9121

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Louise B. Richardson Moog</i>			2. DATE OF DEATH <i>10-22-50</i>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balt.</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			c. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <i>Balt.</i>		
c. Length of stay in Baltimore <i>18 days</i>			d. STREET ADDRESS (If rural, give location) <i>3409 W. Lombard Ave</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>Sept 10, 1881</i>	9. AGE (In years last birthday) <i>69</i>	10. If Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Hugh S. Richardson</i>			14. MOTHER'S MAIDEN NAME <i>Annie Kiger</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. J. H. Sney</i>		
			ADDRESS <i>1716 Leland Ave. Baltimore</i>		

18. <i>171X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) <i>Pneumonia</i> DUE TO			
		(B) <i>Intestinal Obstruction</i> DUE TO			
		(C) <i>Carcinoma of Cervix</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>10-21-50</i>		19B. MAJOR FINDINGS OF OPERATION <i>Intestinal obstruction from cancer C.</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10-21</i> , 19 <i>50</i> to <i>10-22</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>10-22</i> , 19 <i>50</i> and that death occurred at <i>3 a.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Francis H. Wace</i>		23B. ADDRESS <i>Union Memorial Hosp.</i>		23C. DATE SIGNED <i>10-22-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 25/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Pk.</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodlawn. Md.</i>		25. FUNERAL DIRECTOR <i>George F. Witzke</i>		ADDRESS <i>4101 Edmondson</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 24 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams</i>		48a Ave.	

It but was intestinal obstruction due to? Are we correct in assuming this to be underlying cause of death with cancer as a contributing cause?

Was the primary site of cancer, the cervix?

If, ^{considering} not the primary site, was there intestinal obstruction as to the probable primary site.

Was there an operation performed?

If so when and findings — ?

See Document File 50-9121

10-31-50

ES

50 9122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9122

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH

SHUTTZ

2. DATE
OF DEATH September 30, 19503. PLACE OF DEATH:
A. Baltimore City, MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 3-02

D. STREET ADDRESS (If rural, give location)

1149 E. Lombard Street

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years last birthday)

60

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 144X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the alveolar ridge

~~MEGEX~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Thrombo phlebitis of veins of right

~~MEGEX~~ leg

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Durlacher

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED October 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 18 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

SS18 UC

RECEIVED BY THE DIRECTOR

STATE OF OHIO

SS18 UC

SS18 UC

RECEIVED BY THE DIRECTOR

STATE OF OHIO

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STATE OF OHIO

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SS18 UC

RECEIVED BY THE DIRECTOR

STATE OF OHIO

SS18 UC

50 9123

50 9123

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

WILLIAM

JOHNSON

2. DATE
OF
DEATH

October 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1017 W. Lexington Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years
last birthday)

80

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular

disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Dunbar M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

October 14, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 18 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

V S 151

093d

✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

NATIONAL BUREAU OF HEALTH

CERTIFICATE OF DEATH

DEATH RECORD

DEATH RECORD

DEATH RECORD

50 9124
JL# 141778BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9124
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Olin Nixon

2. DATE
OF
DEATH

10-6-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)Baltimore City Hospitals
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

23-01

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

903 S. Sharp St.

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

July 4, 1889

9. AGE (In years
last birthday)

61

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jim Nixon

14. MOTHER'S MAIDEN NAME

Rose Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT
B. C. H. Records, 4940 Eastern Ave.

ADDRESS

18. 150X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Respiratory failure

Instantaneous

DUE TO Aspirated Plug

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Oct. 6, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Esophagus

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-18-50, 19, to Oct. 6, 1950, that I last saw the
deceased alive on Oct. 6, 1950, and that death occurred at 11:02 PM, from the causes and on the date stated above.

23A. SIGNATURE

H. C. H. Records

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

10-18-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 20 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

100-0128

CERTIFICATE OF DEATH

100-0128

100-0128

100-0128

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. 50-23033

1. NAME OF DECEASED
(Type or Print)

Baby Roy Sheffield

2. DATE
OF
DEATH

10/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

26-06

D. STREET ADDRESS (If rural, give location)

1405 Tennant Way

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/10/50

9. AGE (in years
last birthday)If Under 1 Year
Months: Days

10

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Edward Sheffield

14. MOTHER'S MAIDEN NAME

Marie Schultz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 776X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Prematurity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/10/50, 19__, to 10/20/50, 19__, that I last saw the
deceased alive on 10/20/50, and that death occurred at 11:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Virginia

M. D.

23B. ADDRESS

1213 Light Street

23C. DATE SIGNED

10/20/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 24 1950

University Medical School
Commissioner of Health

OCT 23 1950

2518 02

2522 02

2518 02

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. <u>50-23039</u>		50 9126	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Rafferty</u>		2. DATE OF DEATH <u>10/19/50</u>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <u>Baltimore, Maryland</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>24-04</u>	
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <u>South Baltimore General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>	
c. Length of stay in Baltimore Yrs. <u>13</u> Mos. <u>13</u> Days <u>13</u>		d. STREET ADDRESS (If rural, give location) <u>1635 Conington Street</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10/19/50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>3</u>	
13. FATHER'S NAME <u>Donald G. Rafferty</u>		14. MOTHER'S MAIDEN NAME <u>Betty Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. <u>776x</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Remotely</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/19/50</u> , 19 <u>50</u> , to <u>10/19/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10/19/50</u> 19 <u>50</u> and that death occurred at <u>8:20 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Ferguson</u> M. D.		23b. ADDRESS <u>1213 Light Street</u>	23c. DATE SIGNED <u>10/20/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT 24 1950</u>		REGISTRAR'S SIGNATURE <u>Conington Williams, M.D.</u>	
25. FUNERAL DIRECTOR <u>Commissioner of Health</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9127

BIRTH NO. 50-22989

1. NAME OF DECEASED
(Type or Print)

Joseph

Baby Boy Hnida

2. DATE
OF
DEATH

Oct. 24, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

D.C.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

Rural

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

5309 Wasena Ave 5200

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/23/50

9. AGE (In years last birthday)

10 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew

Paul Hnida

14. MOTHER'S MAIDEN NAME

Emma Virginia Holsing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Andrew Hnida

Same

18. 976x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Anoxia Neonatorum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Prematurity

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/23, 1950, to 10/24, 1950, that I last saw the deceased alive on 10/24, 1950, and that death occurred at 5:00 A. m., from the causes and on the date stated above.

23A. SIGNATURE

John J. Fisher

M. D.

23B. ADDRESS

23C. DATE SIGNED

10/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/25/50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven Cem.

24D. LOCATION (City, town, or county)

Anne Arundel Co., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 24 1950

VS 150

11/1/50
Huntington Williams, M.D.

2100 E. Packer & Sons - Balt
Md.

159.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9128****50 9128**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Marie D. McShane*2. DATE
OF
DEATH*10-24-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)*Lutheran Hosp of Md.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*BALTO**15-06*

D. STREET ADDRESS (If rural, give location)

2913 Presbury St

C. Length of stay in Baltimore

*Life*Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

*W*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Widowed*

8. DATE OF BIRTH

Aug. 14, 1894

9. AGE (In years last birthday)

56

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HW

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

BALTO. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Andrew Shaeffer

14. MOTHER'S MAIDEN NAME

*Mary C. Evans*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)*no*

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Sister Mrs. R. Lee same.

ADDRESS

18. *420.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *HACVD: Cardiac failure*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Multiple partial Myocardial Infarcts*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *ACVD generalized**Small, red, pulm infarct left lung base*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10-2*, 19*50*, to *10-24*, 19*50*, that I last saw the deceased alive on *10-24*, 19*50*, and that death occurred at *7:35 AM* from the causes and on the date stated above.

23A. SIGNATURE

John C. Lee

M. D.

23B. ADDRESS

Lutheran Hosp of Md

23C. DATE SIGNED

10-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/27/50

24C. NAME OF CEMETERY OR CREMATORY

Western Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, Md

25. FUNERAL DIRECTOR

Wm. J. Pickner & Sons - Balto

ADDRESS

*093d**md.**OCT 24 1950*

VS 150

8319 08

8319 08



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9129
Registered No.

50 9129

BIRTH NO. 50-21828

1. NAME OF DECEASED
(Type or Print)

Hyatt (Baby Girl)

2. DATE
OF
DEATH

Oct 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland H.L.H. PREMIO

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

Baltimore

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

ESSEX

D. STREET ADDRESS (If rural, give location)

303 POPLAR Rd.

5300

c. Length of stay in Baltimore

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

10-6-50

9. AGE (In years
last birthday)If Under 1 Year
Months: Days

2

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

ALVIN HYATT

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 776x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Prematurity

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 10-6 1950, to 10-8 1950, that I last saw the
deceased alive on 10-8 1950, and that death occurred at 4:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Leonard F. Rosenzweig M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

11 Oct 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9130

BIRTH NO. 50-17703

1. NAME OF DECEASED (Type or Print) ARMSTRONG (Baby Girl)			2. DATE OF DEATH Oct 11, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland HLH PN			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY X		
B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 26-06		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1502 PARTRIDGE CT.		
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 8-26-50	9. AGE (In years last birthday) If Under 1 Year: Days 46 If Under 24 Hours: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME MARGIE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL		

MEDICAL CERTIFICATION

18. 774X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Congestive Heart Failure DUE TO Anemia + Prematurity		INTERVAL BETWEEN ONSET AND DEATH 1 hour
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-26 , 19 50 , to 10-11 , 19 50 , that I last saw the deceased alive on 10-11 , 19 50 , and that death occurred at 6 P m., from the causes and on the date stated above.					
23A. SIGNATURE Thomas C. McPherson M.D.		23B. ADDRESS JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED 10-12-50	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE 175000009128	25. FUNERAL DIRECTOR	ADDRESS

6002 W

200

1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **50 9131**

500
50 9131 (444535)
50-19384

1. NAME OF DECEASED (Type or Print) Baby Queen		2. DATE OF DEATH September 10, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2723 Round Road	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH September 10, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) H Under 1 Year Months: Days H Under 24 Hours Hours: Min. - - - 24
13. FATHER'S NAME Gilford Queen		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Muriel Brooks	
17. INFORMANT Hospital Records		ADDRESS	
18. 754.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Congenital heart disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sep. 10, 1950 to Sep. 10, 1950 , that I last saw the deceased alive on Sep. 10, 1950 , and that death occurred at 9:10 P. M. , from the causes and on the date stated above.			
23A. SIGNATURE Bruce A. Harris Jr.		23B. ADDRESS 601 N. Broadway	
23C. DATE SIGNED Sep. 13, 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY Hope Cemetery		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE 19500300129	
25. FUNERAL DIRECTOR		ADDRESS	

1418

U

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1418

1418



BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9132

Registered No.

BIRTH NO. 50-20464		1. NAME OF DECEASED (Type or Print) Baby GIRL LESTER		2. DATE OF DEATH SEPT 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland H. H. PRE. Nur.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford			
B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ABERDEEN.			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) Rt. 2 6200			
5. SEX FEMALE	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 9-23-50	9. AGE (In years last birthday)	10. Under 1 Year Months: 2 Days: 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME GLEE LESTER		14. MOTHER'S MAIDEN NAME Ruth M.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT JOHNS HOPKINS HOSPITAL	
18. 776x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY		CAUSE OF DEATH (A) PREMATURITY DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-23 19 50 , to 9-26 , 19 50 , that I last saw the deceased alive on 9-26 , 19 50 , and that death occurred at 12:01 am., from the causes and on the date stated above.					
23A. SIGNATURE Lee W. Bass		23B. ADDRESS JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Harford	
24D. LOCATION (City, town, or county)		24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE 19500209130	
24G. FUNERAL DIRECTOR		24H. ADDRESS			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-1 600
50 9133BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9133
Registered No.

BIRTH NO. 50 21365

1. NAME OF DECEASED
(Type or Print)

BABY MOORE

2. DATE
OF
DEATH

SEPT. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTO.

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

UNION MEMORIAL HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

27-15

c. Length of stay in Baltimore

14 HOURS

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

4402 GRANDVIEW AVE.

S. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

SEPT. 26, 1950

9. AGE (In years
last birthday)11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

14 15

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

MR. BEVERLY P. MOORE

14. MOTHER'S MAIDEN NAME

THEA EUGENIA MARY BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT
MR. BEVERLY P. MOOREADDRESS
4402 GRANDVIEW
AVE., BALTO.

18.

776x

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) PREMATURE (42w, 14 3/4)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 6:00 PM, Sept. 26, 1950, to 8:15 AM, Sept. 27, 1950, that I last saw the
deceased alive on Sept. 27, 1950, and that death occurred at 8:15 AM, from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

9/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Cremated

9-27-50

Union Mem. Hosp.

Balto. 18, Md.

10/25/50

Haley

50030

Wm. M. Awan, Dept. of Pathology

F-246 50 9134

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9134

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM EICHLER

2. DATE
OF DEATH

10-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

9-04

D. STREET ADDRESS (If rural, give location)

524 East 30th St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

March 23, 1870

9. AGE (In years
last birthday)

80

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

ENGINEER

10B. KIND OF BUSINESS OR
INDUSTRY

OFFICE BUILDING

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John E. Eichler

14. MOTHER'S MAIDEN NAME

Sarah Elizabeth Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or, unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL
SECURITY NO.

0

17. INFORMANT

ADDRESS

Mrs. Mary Jones 5 Ave

18. 420.0 177X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

PULMONARY EDEMA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

ARTERIOSCLEROTIC HEART DISEASE

(C)

INTERVAL BETWEEN
ONSET AND DEATH

—

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CARCINOMA OF PROSTATE

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 17, 1950, to Oct 22, 1950, that I last saw the
deceased alive on Oct 22, 1950, and that death occurred at 2:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Francis H. Wooten

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

10-22-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10/25/50

24C. NAME OF CEMETERY OR CREMATORY

WESTERN

24D. LOCATION (City, town, or county)

EDMONDSON AVE

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 25 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

JOHN F. DENNY, Inc. 715 LIGHT ST -30

ADDRESS

1018 02

1018 02



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sarah Brave

Registered No.

2. DATE OF DEATH October 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

5101 Gwynn Oak Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

28-02

D. STREET ADDRESS (If rural, give location)

5101 Gwynn Oak Ave

c. Length of stay in Baltimore

33 Yrs

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

May 15, 1880

9. AGE (in years

last birthday)

70

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Esther Solomon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT
Mr Louis Sagner

ADDRESS

2606 Queen Anne Road

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

DUE TO

10 years

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June, 1946, to October 23, 1950, that I last saw the deceased alive on Oct. 23, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Dorothy J. Schwartz

23B. ADDRESS

2320 Eutaw Place

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

October 25, 1950 Beth Tfiloh Cemetery

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

Baltimore MD

(State)

DATE RECEIVED BY LOCAL REGISTRAR

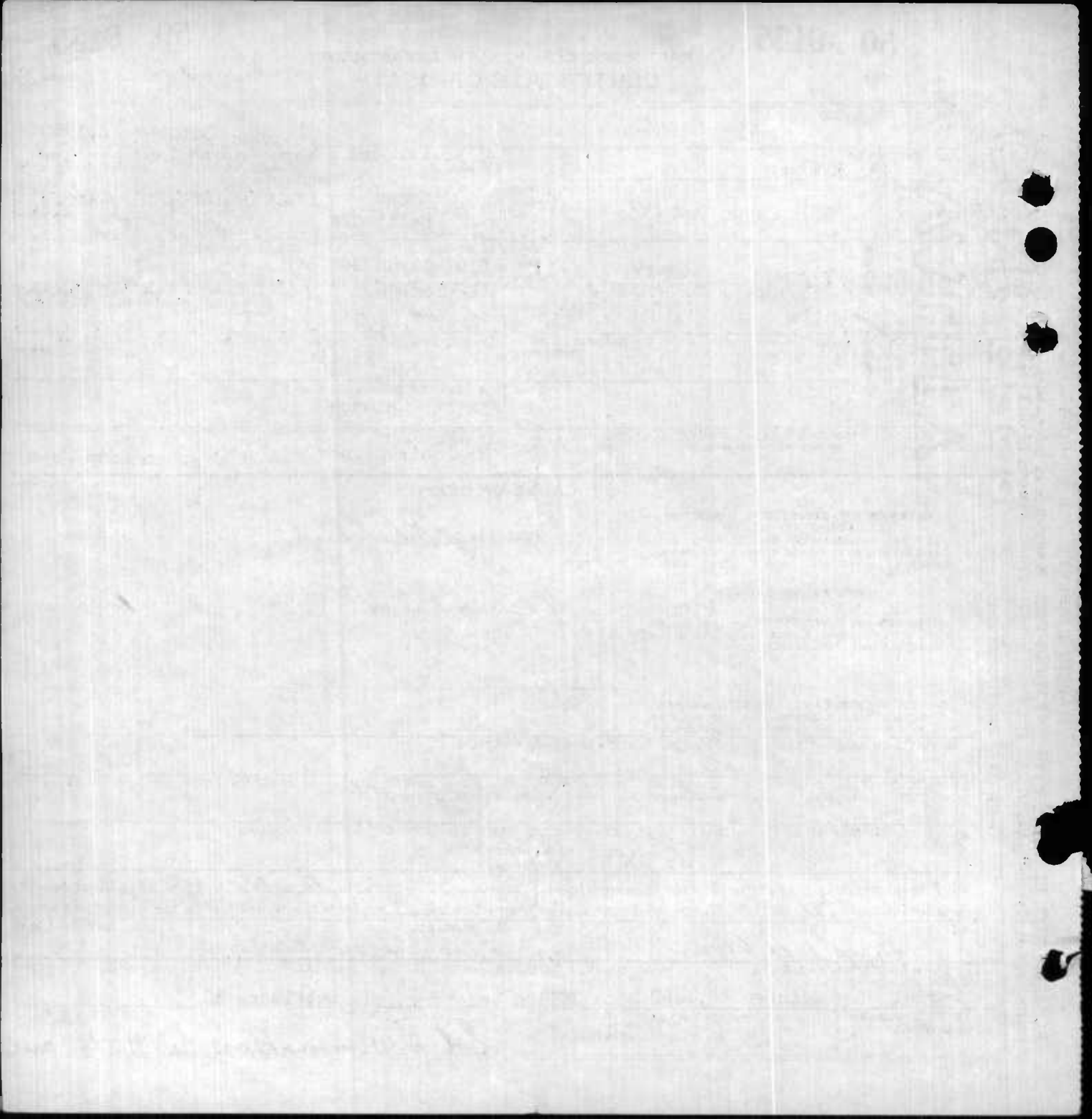
REGISTRAR'S SIGNATURE

Timothy J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Sol Lewinson & Bros W North ave



W-160
50 9136BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9136

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Albert Wever

2. DATE
OF
DEATH

October 23, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 238 S. Patterson Pk

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore Md. 1-05

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

238 S. Patterson Pk. Ave.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

8/9/1895

9. AGE (in years
last birthday)

55

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

ELEC. COM. RETIRED

10B. KIND OF BUSINESS OR
INDUSTRY

CON. IT.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Philip Wever

14. MOTHER'S MAIDEN NAME

Augusta Frantz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, oo or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
None

17. INFORMANT

ADDRESS

Miss Alma Wever 238 S. Patterson Pk.

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Myocardial Heart Disease

7 days -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Arterio-Sclerotic Hypertension C.R.O.

20 yrs -

(C) DUE TO

Chronic Coronal Heart Disease

32 yrs -

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1951, to October 23, 1950 that I last saw the deceased alive on Oct 23, 1950. and that death occurred at 2:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Daudler

M. D.

23B. ADDRESS

2348 Eastern Ave

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 27, 50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cem.

24D. LOCATION (City, town, or county)

Taylor Av. Balto. Co.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Paul A. Heemann 6067 Harford Rd.

VS 150

29024

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

As
middle

50 9137

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9137
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louise Schellenberger 163678

2. DATE OF DEATH
OCT 23 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Osler - 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION
JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Eng. Council, 5200

c. Length of stay in Baltimore

Yrs.
Mos.
DaysD. STREET ADDRESS (If rural, give location)
Oak Rd. & Hickory Ave.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

female

white

S.

3-2-89

61

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Md.

13. FATHER'S NAME

August Schellenberger

14. MOTHER'S MAIDEN NAME

Anna Schweighofer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) coronary Thrombosis
(C) " arteriosclerosisII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-20-1950 to 10-23-1950 that I last saw the deceased alive on 10-23-1950 and that death occurred at 11:20 P. M. from the causes and on the date stated above.

23A. SIGNATURE

Thomas J. Walsh

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/27/50

New Cathedral

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

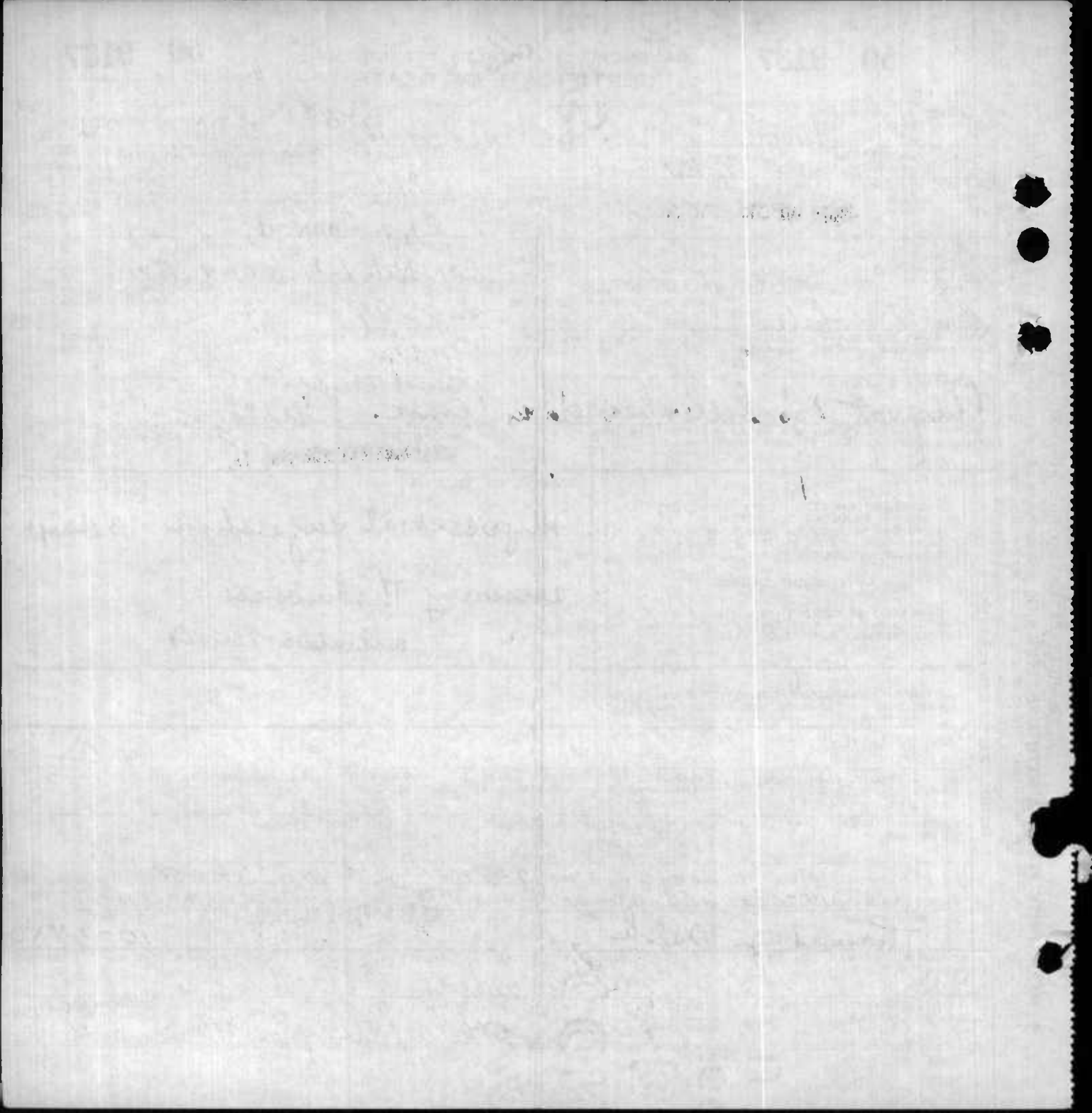
25. FUNERAL DIRECTOR

ADDRESS

OCT 25 1950

Eustace J. Williams, M.D.

Philip Herwig Sons, 2024 Orleans St



LC
141637

50 9138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9138

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Richard Samuel Harrison		2. DATE OF DEATH 10-24-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give town) Baltimore Parkville	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 1435 Taylor Ave	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 23, 1884
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Building	9. AGE (In years; last birthday) 66
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Harrison		14. MOTHER'S MAIDEN NAME Sally Ann Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Records* Baltimore City Hospitals		ADDRESS 4940 Eastern Ave	

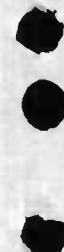
18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Arteriosclerotic (Cardio) DUE TO (A) Heart Disease, with failure	CAUSE OF DEATH Hypertensive Arteriosclerotic (Cardio) DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH Vascular Years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Emphysema Broncho Pneumonia		Years _____

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 14 , 19 50 , to Oct. 24 , 19 50 , that I last saw the deceased alive on Oct. 24 , 19 50 , and that death occurred at 1:20 AM , from the causes and on the date stated above.					
23A. SIGNATURE [Signature]		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 10-24-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/27/50		24C. NAME OF CEMETERY OR CREMATORY Gruid Ridge	
24D. LOCATION (City, town, or county) (State) Parkville Md.		25. FUNERAL DIRECTOR Wm. C. C. Inc. 1217 St. Paul St.			
DATE RECEIVED BY LOCAL REGISTRAR OCT 25 1950		REGISTRAR'S SIGNATURE Huntington Williams, Jr.		ADDRESS 1217 St. Paul St.	

80 0138

80 0138

STATE OF TEXAS
COUNTY OF DALLAS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9139
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) MALCOLM DENNIS GETCHELL			2. DATE OF DEATH Oct. 23, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY V-35		
B. FULL NAME OF HOSPITAL OR INSTITUTION US Marine Hospital Wyman Pk. Drive & 31st St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meadville		
C. Length of stay in Baltimore 95 days Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 701 Brawley Avenue		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 2/28/24		9. AGE (In years, last birthday) 26
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ordinary seaman		10B. KIND OF BUSINESS OR INDUSTRY Seafarer	11. BIRTHPLACE (State or foreign country) Me.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Warren D. Getchell			14. MOTHER'S MAIDEN NAME Gladys Moulton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2 Marine Corps		16. SOCIAL SECURITY NO. 217-26-5094	17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.		

18. 570.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Intestinal obstruction DUE TO (B) Adhesion, postoperative, following operation for regional ileitis with perforation DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH 17 days Operation 7/22/50 & 8/7/50

19A. DATE OF OPERATION 7/22 & 8/7/50		19B. MAJOR FINDINGS OF OPERATION Multiple perforations of small intestines		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 20 , 19 50 , to Oct. 23 , 19 50 , that I last saw the deceased alive on Oct. 23 , 19 50 , and that death occurred at 2:40A m., from the causes and on the date stated above.					
23A. SIGNATURE John L. Wilson, Medical Director		23B. ADDRESS US Marine Hospital, Balto, Md.		23C. DATE SIGNED 10/23/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 10/26/50	24C. NAME OF CEMETERY OR CREMATORY U.S. National	24D. LOCATION (City, town, or county) (State) Balto, Md		
DATE RECEIVED BY LOCAL REGISTRAR OCT 25 1950		REGISTRAR'S SIGNATURE Wm. C. Williams, Jr.		25. FUNERAL DIRECTOR ADDRESS Wm. Cook Inc. 1217 St. Paul St.	

VS 150

673 55

1224

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8138

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DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

50

1

190-12-115

DEATH

ARTIST

RECEIVED
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
JAN 10 1900

DEPARTMENT OF HEALTH

BUREAU OF VITAL RECORDS

RECEIVED

JAN 10 1900

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DEPARTMENT OF HEALTH

BUREAU OF VITAL RECORDS

RECEIVED

JAN 10 1900

M-400
50 9140BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9140

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John F. Mahle

2. DATE
OF
DEATH

Oct 24, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 330 N Hillow St

B. FULL NAME OF
(If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE B. COUNTY
330 N Hillow StC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore Md

D. STREET ADDRESS (If rural, give location)

330 N Hillow St 20-07

c. Length of stay in Baltimore

30 Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Retired

8. DATE OF BIRTH

Mar 8th9. AGE (In years
last birthday)

77

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Produce Veg.

10B. KIND OF BUSINESS OR
INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John C. Mahle

14. MOTHER'S MAIDEN NAME

Mary Gerwig

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

Mrs Catherine J. Mahle 330 N Hillow St

ADDRESS

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive C-V Disease

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1946 to October, 1950, that I last saw the
deceased alive on October 23, 1950, and that death occurred at 7 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Morris W. Sclenberg

23B. ADDRESS

410 N. Hillow St.

23C. DATE SIGNED

October 24, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Oct 27-50

24C. NAME OF CEMETERY OR CREMATORY

Loughan Park Cem

24D. LOCATION (City, town, or county)

Frederick Ave

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

M. W. Sclenberg

25. FUNERAL DIRECTOR

Chas P. Towell 2427 Calverton Ave

ADDRESS

VS 150

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

6x8 in

204348

410 N. 1st St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9141
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Susana Kirschner

2. DATE
OF
DEATH

Oct 23 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Beech Hill Nursing

B. FULL NAME OF (If not in hospital or institution, give street address location)
HOSPITAL OR INSTITUTE

Beech Hill Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

2226 Lake Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore and 8-01

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Feb 26

9. AGE (In years
last birthday)

83

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House wife, self

10B. KIND OF BUSINESS OR
INDUSTRY

Retired

13. FATHER'S NAME

Henry Hoffman

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Elizabeth Kauer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr Jacob Kirschner

18. E902.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Cardiac Thrombosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Fractured Hip

CERTIFICATION APPROVED BY

William Wood M.D.

OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)
accident21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)
home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2226 Lake Avenue

81

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

September 13, 1950 5 p.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell from chair to floor

22. I hereby certify that I attended the deceased from Sept 6, 1950, to Oct 23, 1950, that I last saw the deceased alive on 10/17, 1950, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Amelia Link Shepherd

M. O.

23B. ADDRESS

2226 E. Lake Ave

23C. DATE SIGNED

10/26/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 26-50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county)

Calmonet sou Ave

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 25 1950

REGISTRAR'S SIGNATURE

William Wood M.D.

25. FUNERAL DIRECTOR

Chas. P. Towell 2427 Calmonet sou Ave

ADDRESS

2211



50 9142

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9142

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sophie Caroline Ulrich

2. DATE
OF
DEATH

Oct. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

none

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1739 Eutaw Place

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

14-01

D. STREET ADDRESS (If rural, give location)

1739 Eutaw Place

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Oct. 4, 1875

9. AGE (In years
last birthday)

75

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of worklog life, even if retired)

dietitian

10B. KIND OF BUSINESS OR
INDUSTRYChildren's Rehabilitation
Center

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

John H. Ullrich

14. MOTHER'S MAIDEN NAME

Marie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Carlotta Heller 1739 Eutaw Place

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Acute pulmonary edema

35 mins.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hypertension
(C) Arteriosclerotic heart disease

30 years.

2 years.

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from April 1945 to October, 1950, that I last saw the
deceased alive on 24 Oct. 1950. and that death occurred at 1207 Eutaw Pl. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

10/26/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 25 1950

John O. Mitchell & Sons, Inc.-1900 Eutaw Place

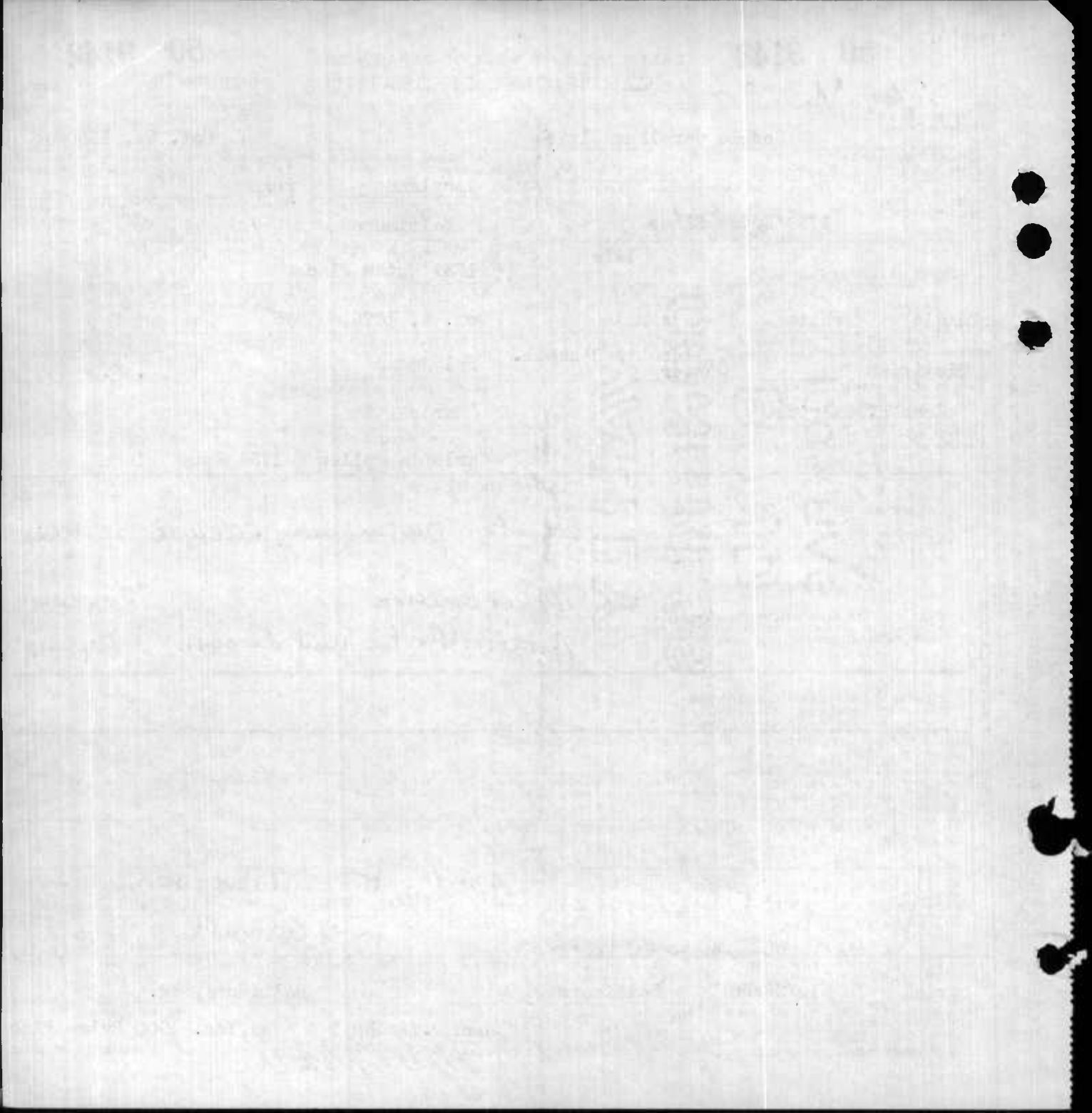
VS 150

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



50 9143

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9143
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ORESTE TALUCCI			2. DATE OF DEATH October 24 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 1523 Ralworth Rd.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 1523 Ralworth Rd.			E. Yrs. Mos. Days		
c. Length of stay in Baltimore			8. DATE OF BIRTH November 14 1884		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	9. AGE (In years last birthday) 65		10. Under 1 Year Months: Days Hours: Min. 10 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Tailor Shop		11. BIRTHPLACE (State or foreign country) Chieti Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Giuseppe Talucci		
14. MOTHER'S MAIDEN NAME Olimpia Poggi			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 212-03-3679			17. INFORMANT ADDRESS Lucy Talucci (Wife) 1523 Ralworth Rd.		

18. 581.0	CAUSE OF DEATH Hepatic Perihoses	INTERVAL BETWEEN ONSET AND DEATH 15 mos.
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
(A) DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(B) DUE TO		
(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug-10 - 1950 , to Oct 24, 1950 , that I last saw the deceased alive on Oct 24, 1950 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above.					
23A. SIGNATURE Anthony F. Carozza		23B. ADDRESS 5217 YORK Rd		23C. DATE SIGNED 10-25-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE October 27/50		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Bal.Md.		25. FUNERAL DIRECTOR ADDRESS 322 S. High St.			
DATE RECEIVED BY LOCAL REGISTRAR OCT 25 1950		REGISTRAR'S SIGNATURE William H. Williams		25. FUNERAL DIRECTOR ADDRESS 322 S. High St.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9144G 436 50 9144
BIRTH NO. 50-14143

1. NAME OF DECEASED (Type or Print) GARRETT D. GOLDER		2. DATE OF DEATH Oct. 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1130 Woodyear St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-02	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1130 Woodyear St.	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH 6-29-50 7-12-52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) Months: 3 Days: 25
13. FATHER'S NAME William GOLDER		11. BIRTHPLACE (State or foreign country) Baltimore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. none		14. MOTHER'S MAIDEN NAME Beatrice Holland	
17. INFORMANT Wm GOLDER 1130 WOODEAR ST		ADDRESS	

18. **492X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Interstitial pneumonitis**

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☒

23C. DATE SIGNED

Oct. 23, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

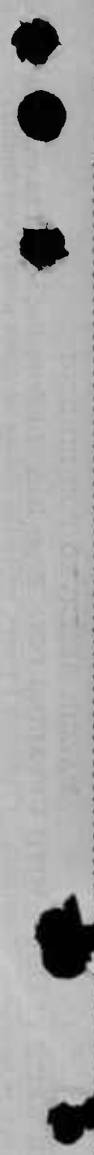
1918

1918

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1918



<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of death</p>	
<p>5. Place of death</p>		<p>6. Cause of death</p>		<p>7. Nature of disease</p>		<p>8. Duration of disease</p>	
<p>9. Name of physician</p>		<p>10. Name of funeral director</p>		<p>11. Name of undertaker</p>		<p>12. Name of cemetery</p>	
<p>13. Name of registrar</p>		<p>14. Name of health officer</p>		<p>15. Name of coroner</p>		<p>16. Name of jury</p>	
<p>17. Name of witness</p>		<p>18. Name of witness</p>		<p>19. Name of witness</p>		<p>20. Name of witness</p>	
<p>21. Name of witness</p>		<p>22. Name of witness</p>		<p>23. Name of witness</p>		<p>24. Name of witness</p>	
<p>25. Name of witness</p>		<p>26. Name of witness</p>		<p>27. Name of witness</p>		<p>28. Name of witness</p>	
<p>29. Name of witness</p>		<p>30. Name of witness</p>		<p>31. Name of witness</p>		<p>32. Name of witness</p>	
<p>33. Name of witness</p>		<p>34. Name of witness</p>		<p>35. Name of witness</p>		<p>36. Name of witness</p>	
<p>37. Name of witness</p>		<p>38. Name of witness</p>		<p>39. Name of witness</p>		<p>40. Name of witness</p>	
<p>41. Name of witness</p>		<p>42. Name of witness</p>		<p>43. Name of witness</p>		<p>44. Name of witness</p>	
<p>45. Name of witness</p>		<p>46. Name of witness</p>		<p>47. Name of witness</p>		<p>48. Name of witness</p>	
<p>49. Name of witness</p>		<p>50. Name of witness</p>		<p>51. Name of witness</p>		<p>52. Name of witness</p>	
<p>53. Name of witness</p>		<p>54. Name of witness</p>		<p>55. Name of witness</p>		<p>56. Name of witness</p>	
<p>57. Name of witness</p>		<p>58. Name of witness</p>		<p>59. Name of witness</p>		<p>60. Name of witness</p>	
<p>61. Name of witness</p>		<p>62. Name of witness</p>		<p>63. Name of witness</p>		<p>64. Name of witness</p>	
<p>65. Name of witness</p>		<p>66. Name of witness</p>		<p>67. Name of witness</p>		<p>68. Name of witness</p>	
<p>69. Name of witness</p>		<p>70. Name of witness</p>		<p>71. Name of witness</p>		<p>72. Name of witness</p>	
<p>73. Name of witness</p>		<p>74. Name of witness</p>		<p>75. Name of witness</p>		<p>76. Name of witness</p>	
<p>77. Name of witness</p>		<p>78. Name of witness</p>		<p>79. Name of witness</p>		<p>80. Name of witness</p>	
<p>81. Name of witness</p>		<p>82. Name of witness</p>		<p>83. Name of witness</p>		<p>84. Name of witness</p>	
<p>85. Name of witness</p>		<p>86. Name of witness</p>		<p>87. Name of witness</p>		<p>88. Name of witness</p>	
<p>89. Name of witness</p>		<p>90. Name of witness</p>		<p>91. Name of witness</p>		<p>92. Name of witness</p>	
<p>93. Name of witness</p>		<p>94. Name of witness</p>		<p>95. Name of witness</p>		<p>96. Name of witness</p>	
<p>97. Name of witness</p>		<p>98. Name of witness</p>		<p>99. Name of witness</p>		<p>100. Name of witness</p>	

D-552
50
Hospital Disposal

DOWNING

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9145

Registered No. _____

BIRTH NO. 50-22082

1. NAME OF DECEASED
(Type or Print)

Baby Girl Downing

2. DATE
OF
DEATH

October 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

Yrs.
Mos.
Days

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

908 Shuter St. Shuter

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10-15-50

9. AGE (in years
last birthday)If Under 1 Year
Months: Days

4

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lewis Downing

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

CAUSE OF DEATH

Prematurity

INTERVAL BETWEEN
ONSET AND DEATH

Life

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-15, 1950, to 10-19, 1950, that I last saw the
deceased alive on 10-19, 1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas C. McPherson

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Hopkyns

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

ADDRESS

OCT 25 1950

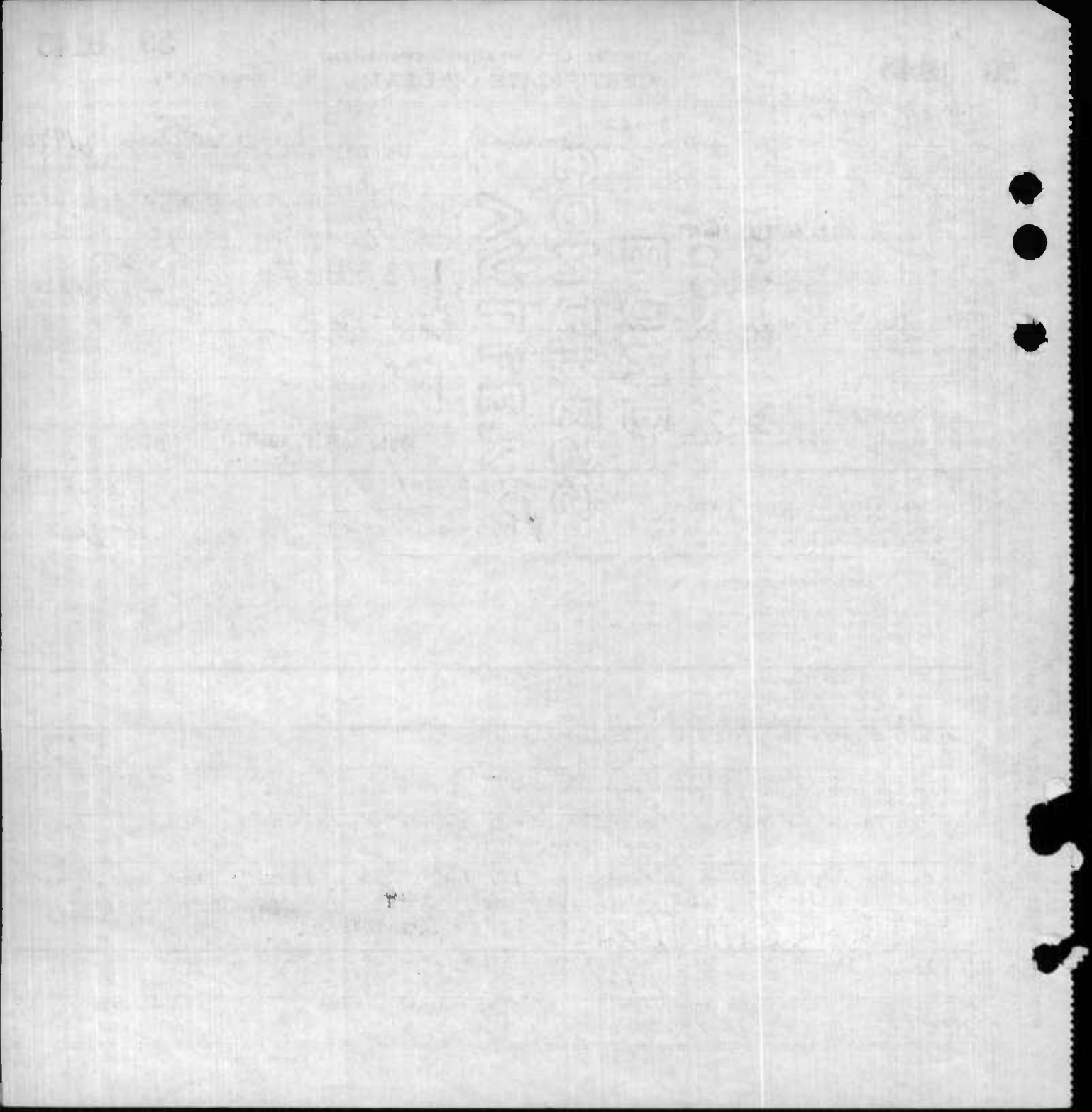
VS 150

159.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9146

Registered No.

BIRTH NO. <i>50-18418</i>		2. DATE OF DEATH <i>OCT 22 1950</i>	
1. NAME OF DECEASED (Type or Print) <i>Baby girl #2</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>25-32</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		C. CITY OR TOWN (If outside corporate limits write RURAL and give township) <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		D. STREET ADDRESS (If rural, give location) <i>3038 SEAMON AVE.</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		8. DATE OF BIRTH <i>8-24-50</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>negro</i>	9. AGE (in years last birthday) <i>12</i>	10. UNDER 1 Year Months: Days <i>29</i>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
10B. KIND OF BUSINESS OR INDUSTRY		14. MOTHER'S MAIDEN NAME	
13. FATHER'S NAME <i>Enos Johnson</i>		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
18. <i>776x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Prematurity</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>Life</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8-24-</i> , 1950 to <i>10-22-</i> , 1950 that I last saw the deceased alive on <i>10-22-</i> , 1950 and that death occurred at <i>4:45 A</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>Thomas C. McPherson</i> M. D.		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	
23C. DATE SIGNED			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY <i>Hosp Disposal</i>		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 25 1950</i>		REGISTRAR'S SIGNATURE <i>Anthony J. Williams</i>	
25. FUNERAL DIRECTOR		ADDRESS	

RECEIVED
JAN 10 1964
FBI - NEW YORK

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9147**BIRTH NO. **50-21948**1. NAME OF DECEASED
(Type or Print)**Baby Girl Peaks- Bertha "B"**2. DATE
OF
DEATH**Oct. 21, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4940 Eastern Avenue**Maryland**

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1006 N. Washington Street

c. Length of stay in Baltimore

LifeYrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct. 15, 1950

9. AGE (In years last birthday)

N. B.11 Under 1 Year
Months: Days**6**11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Oakley Peaks

14. MOTHER'S MAIDEN NAME

Bertha Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue18. **762.5**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) **Fetal Atelectasis**

DUE TO

6 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Prematurity**

DUE TO

6 Days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from **10-15**, 19 **50**, to **10-21**, 19 **50**, that I last saw the deceased alive on **10-21**, 19 **50**, and that death occurred at **1 P.** m., from the causes and on the date stated above.

23A. SIGNATURE

[Signature]

23B. ADDRESS

M. D. 4940 Eastern Avenue

23C. DATE SIGNED

10-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

10-23-50

24C. NAME OF CEMETERY OR CREMATORY

B. C. H. Crematory

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

ADDRESS

OCT 25 1950

30 3117

RECEIVED BY THE OFFICE OF THE

SECRETARY OF THE ARMY

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9148
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDITH JOHNSON

2. DATE
OF
DEATH

Oct. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

12 W York St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreD. STREET ADDRESS (If rural, give location)
12 W York St

c. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

Col

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Sept. 22, 1899

9. AGE (In years
last birthday)

51

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life even if retired)

at home

10B. KIND OF BUSINESS OR
INDUSTRY11. BIRTHPLACE (State or foreign country)
Baltimore Md12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Charles Johnson

ADDRESS

12 W York St

18. 442X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Chronic Myocarditis

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

6 mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hypertension
neglective

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 10, 1950, to Oct 24, 1950, that I last saw the
deceased alive on Oct 19, 1950, and that death occurred at 8 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Dan Trauer

M. D.

23B. ADDRESS

12 W York St

23C. DATE SIGNED

10/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Oct 29, 50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington T. Johnson

FUNERAL DIRECTOR

H. B. Springer - 13941 Family St

ADDRESS

OCT 25 1950

30 312

UNITED STATES DEPARTMENT OF AGRICULTURE

CERTIFICATE OF ORIGIN

312

No. 312	
Date of Issue	
Place of Issue	
Name of Issuer	
Name of Recipient	
Address of Recipient	
Description of Goods	
Quantity	
Value	
Signature of Issuer	
Signature of Recipient	
Date of Receipt	
Remarks	



R-740
50 9149BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9149

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sister Mary Hilda Russell O.S.P.

2. DATE
OF
DEATH

Oct 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 501 E. Chase St

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

St. Frances Convent

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write full name and give
township)

Baltimore

10-01

D. STREET ADDRESS (If rural, give location)

501 E. Chase St

c. Length of stay in Baltimore

3 yrs

Yrs.
Mos.
Days

5. SEX

7.

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 13, 1870

9. AGE (In years,
last birthday)

80

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work during most of working life, even if retired)

Religious

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Adams County, Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry P. Russell

14. MOTHER'S MAIDEN NAME

Emily Jane Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mother M. Lewis O.S.P. 501 E. Chase St

18. 422.1

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis

year

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1st, 1950, to Oct. 24th, 1950, that I last saw the
deceased alive on Oct 23rd, 1950, and that death occurred at 6 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Cantland

23B. ADDRESS

15 E. Biddle St.

23C. DATE SIGNED

Oct 24/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Oct 26/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem. Frederick Rd. Bal Md.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Robert A. Elliott's Daughter

VS 150

0932 1129 N. Caroline St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN UNFADING INK. Every item of information should be clearly and legibly. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 9150**

BIRTH NO.

50 9150

50-21830

1. NAME OF DECEASED
(Type or Print)

CLAUDIA

ROSTEK

2. DATE
OF
DEATH

Oct. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Baltimore City Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Turners Station

D. STREET ADDRESS (If rural, give location)

3411 Sollers Point Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct. 4 - 1950

9. AGE (In years
last birthday)If Under 1 Year
Months: Days

20

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Daniel Rostek

14. MOTHER'S MAIDEN NAME

Veronica Jaskulska

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Daniel Rostek 3411 Sollers Pt. Rd.

18. 754.5

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Congenital heart disease-coarctation
DUE TO of aorta and subaortic stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., In or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

B. F. Fisher

23B. CHIEF MEDICAL EXAMINER.....☒
M.D. ASSISTANT MEDICAL EXAMINER.....☐23C. DATE SIGNED
Oct. 25, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct. 26-50

Holy Rosary

Balto. Co.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 25 1950

Wm. J. Williams

Wm. S. F. Kowski 2007 Eastern

0212

02

STATE OF NEW YORK
CERTIFICATE OF DEATH

0212

02



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9151

Registered No. _____

BIRTH NO. 50-24166

1. NAME OF DECEASED
(Type or Print) Nelson Susy D.

2. DATE OF DEATH Oct. 25, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION MERCY Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, Md.

c. Length of stay in Baltimore 8 hrs -

D. STREET ADDRESS (If rural, give location)
2938 CORNELL RD

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
INFANT

8. DATE OF BIRTH Oct. 24, 1950

9. AGE (In years last birthday) 8 yrs

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.

13. FATHER'S NAME
George Nelson

14. MOTHER'S MAIDEN NAME
MERYL Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT
MOTHER

ADDRESS
SAME

18. 776x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH
8

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Pneumonia

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 24, 1950, to Oct 25, 1950, that I last saw the deceased alive on Oct 25, 1950, and that death occurred at 12:30 am., from the causes and on the date stated above.

23A. SIGNATURE
Mary E. Matthews

23B. ADDRESS
Mercy Hospital

23C. DATE SIGNED
Oct. 25, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE
10/26/50

24C. NAME OF CEMETERY OR CREMATORY
Belair Memorial

24D. LOCATION (City, town, or county) (State)
Belair Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE
Washington Phillips

25. FUNERAL DIRECTOR
William Funeral Home

ADDRESS
Stundalk Ave

OCT 25 1950

VS 150

159.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ENC 02

RECEIVED AT THE U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

1-10-68

01

RECEIVED AT THE U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9152

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edward GILLEN

2. DATE
OF
DEATH

10-23-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hosp

Yrs.
Mos.
Days

c. Length of stay in Baltimore

1 mo

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Mar 29 1873 77

9. AGE (In years
last birthday)

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR
INDUSTRY

Rupp Co.

11. BIRTHPLACE (State or foreign country)

Relay Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Hugh Gillen

14. MOTHER'S MAIDEN NAME

Allen McElahan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

ADDRESS

Miss Loretta M Burns, Sutton

18. E903.7

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cachexia
DUE TO uremia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Pneumonia
DUE TO Fr. left femur

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☒
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, etc.)

Harford Convalescent
Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Harford Rd.
Harford Convalescent Home

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Aug. ? 1950

21E. INJURY OCCURRED
WHILE AT ☐ WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slipped &
Fell to floor

22. I hereby certify that I attended the deceased from 9-28, 1950 to 10-23, 1950, that I last saw the
deceased alive on 10-23, 1950, and that death occurred at 4:15 P. M., from the causes and on the date stated above.

23A. SIGNATURE

R. C. Spaulding Jr.

M. D.

23B. ADDRESS

Univ. Hosp.

23C. DATE SIGNED

10-23-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/26/50

24C. NAME OF CEMETERY OR CREMATORY

St. Augustine

24D. LOCATION (City, town, or county)

Elkridge Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 25 1950

REGISTRAR'S SIGNATURE

John J. Brown

25. FUNERAL DIRECTOR

John J. Brown

ADDRESS

186a St.

VS 150

N821.1

186a St.

SEAL OF

SEAL OF



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9153

BIRTH NO. 200 9153			2. DATE OF DEATH October 24, 1950		
1. NAME OF DECEASED (Type or Print) WILLIAM TEAGUE			3. PLACE OF DEATH: A. Baltimore City, Maryland		
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			D. STREET ADDRESS (If rural, give location) 1920 Madison Avenue		
c. Length of stay in Baltimore Yrs. Mos. Days			5. SEX male 6. COLOR OR RACE colored 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Contractors		
13. FATHER'S NAME Ludie Teague			14. MOTHER'S MAIDEN NAME Ellen Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 214-22-3891		
17. INFORMANT Ellen Smith ADDRESS 1920 Madison Ave			11. BIRTHPLACE (State or foreign country) N. C.		
12. CITIZEN OF WHAT COUNTRY?			9. AGE (In years last birthday) 21		
18. E 981X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) Gunshot wound of chest DUE TO (B) Left hemothorax DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) cafe			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Dreamland Cafe, 1007 Pennsylvania Ave.		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY October 23, 1950 12.30 a.m.			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
21F. HOW DID INJURY OCCUR? firearms			22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE William Teague			23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/> 23C. DATE SIGNED Oct. 24, 1950		
24A. BURIAL, CREMATION, REMOVAL (Specify) Oct 28.50			24B. DATE Oct 28.50		
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cent			24D. LOCATION (City, town, or county) (State) A.A. Cornet		
DATE RECEIVED BY LOCAL REGISTRAR OCT 25 1950			REGISTRAR'S SIGNATURE		
25. FUNERAL DIRECTOR Isaac Brown Son			ADDRESS 1054 Montg omery St		

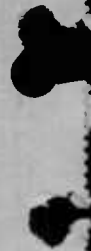
8133

30

STATE OF DEATH

8133

30



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9154

Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Cobb

2. DATE
OF
DEATH 10/23/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

1017 Edmondson Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

D. STREET ADDRESS (If rural, give location)

1017 Edmondson Avenue

C. Length of stay in Baltimore 15 Yrs.

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9/19/1869

9. AGE (in years
last birthday)

81 80

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Goldsboro N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Eli Cobb

14. MOTHER'S MAIDEN NAME

Diana

Cobb

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.17. INFORMANT
ADDRESS
Luille Anderson 1012 Edmondson Ave

18. 592X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1-1950 to 10-23-1950 that I last saw the
deceased alive on 10-23-1950, and that death occurred at 10:42m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/29/1950

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

Goldsboro N.C.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

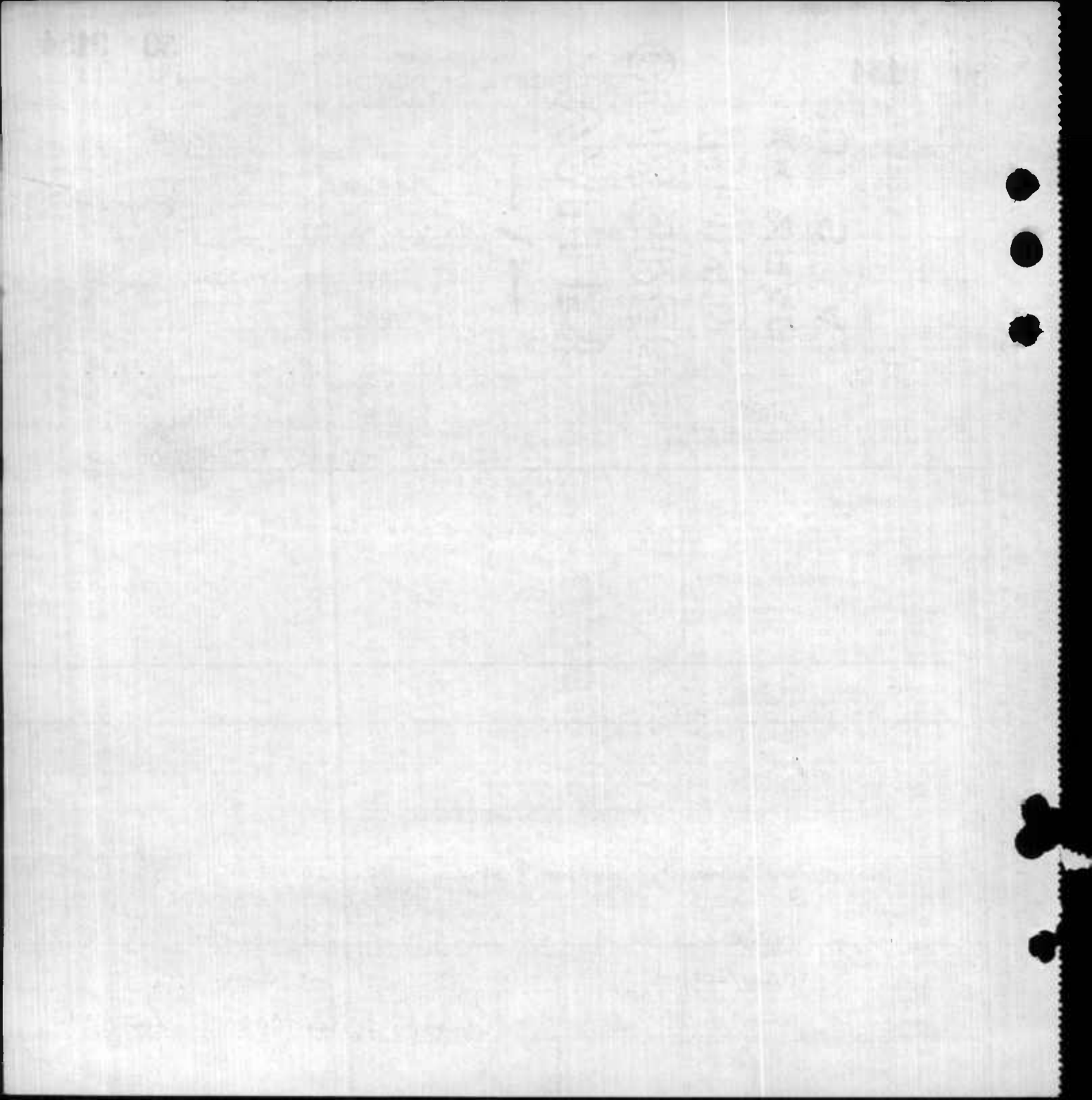
ADDRESS

OCT 25 1950

VS 150

Eugene Wilson 1000 Brantly Ave

131a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9155
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) DAVID Barnes			2. DATE OF DEATH October 24, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 20 yrs.			D. STREET ADDRESS (If rural, give location) 1021 W. Lexington Street		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 4/3/1901	9. AGE (In years last birthday) 49	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10B. KIND OF BUSINESS OR INDUSTRY On General	11. BIRTHPLACE (State or foreign country) Richmond Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Williams Barnes			14. MOTHER'S MAIDEN NAME Mary Ellen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. _____	17. INFORMANT Arthur Barnes		
			ADDRESS 777 W. Mybury		

<p>18. 161X</p> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p align="center">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) Carcinoma of the larynx</p> <p>(B) Generalized emaciation</p> <p>(C) _____</p>
<p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William [Signature]		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR		23C. DATE SIGNED Oct. 24, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/28/50	24C. NAME OF CEMETERY OR CREMATORY mt Calvary Cem	24D. LOCATION (City, town, or county) (State) Brooklyn Md		
DATE RECEIVED BY LOCAL REGISTRAR OCT 25 1950	REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR Elroy O. Wilson 1100 Brantigan		

V S 151

97095

047a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9155

50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9155

50



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9156

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DIANE Cecile Thomas. #80837

2. DATE
OF
DEATH

OCT 25 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland H. H. W. Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

HUNTER

D. STREET ADDRESS (If rural, give location)

6800

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female negro

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

8-28-50

9. AGE (In years
last birthday)10. Under 1 Year
Months: Days

2

11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wilson Thomas

14. MOTHER'S MAIDEN NAME

Mary R

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

193X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Hydrocephalus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Brain tumor (Glioma)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

(over)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT ☐NOT WHILE ☐

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-30-1950 to 10-25-1950, that I last saw the
deceased alive on 10-25-1950, and that death occurred at 1:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

L. M. Bass

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10/27/50

24C. NAME OF CEMETERY OR CREMATORY

St. MARY'S CEM

24D. LOCATION (City, town, or county)

WOODLAND MD.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

"Glioma", (malignant tumor)

See Document File 50-9156

11-14-50

ES

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9157

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Dora L. Keller

2. DATE
OF
DEATH

Oct. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Baltimore**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
B. COUNTY **Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Cordova Apts. Lake Dr.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

c. Length of stay in Baltimore **Life, 84 yrs.**
Yrs. **84**
Mos. **0**
Days **0**

D. STREET ADDRESS (If rural, give location)
Cordova Apts. Lake Dr.

5. SEX
F

6. COLOR OR RACE
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH
Apr. 21, 1866

9. AGE (In years last birthday)
84

10 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Germany

12. CITIZEN OF WHAT COUNTRY?
U S A

13. FATHER'S NAME

Lippman Lowenstein

14. MOTHER'S MAIDEN NAME

Fannie Sonnenberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **Cordova Apts. Lake Dr.**
Mrs. Justine Gundersheimer

18. **334X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Bronchopneumonia**

6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Senility**
Cerebral arteriosclerosis

15 years

(C) **Cerebral arteriosclerosis**

15 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uremia - generalized arteriosclerosis

?

19A. DATE OF OPERATION **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **August, 1946** to **Oct. 24, 1950** that I last saw the deceased alive on **Oct. 24, 1950**, and that death occurred at **7:15 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE

Herbert J. Gundersheimer Jr.

M. D.

23B. ADDRESS

Riviera Apts Lake Dr

23C. DATE SIGNED

Oct. 25, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 26, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Hebrew

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 25 1950

David J. Gundersheimer

David J. Gundersheimer

1902 Eutaw Place

VS 150

107.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other disposition		20. Signature of other disposition	
21. Signature of other disposition		22. Signature of other disposition		23. Signature of other disposition		24. Signature of other disposition	
25. Signature of other disposition		26. Signature of other disposition		27. Signature of other disposition		28. Signature of other disposition	
29. Signature of other disposition		30. Signature of other disposition		31. Signature of other disposition		32. Signature of other disposition	
33. Signature of other disposition		34. Signature of other disposition		35. Signature of other disposition		36. Signature of other disposition	
37. Signature of other disposition		38. Signature of other disposition		39. Signature of other disposition		40. Signature of other disposition	
41. Signature of other disposition		42. Signature of other disposition		43. Signature of other disposition		44. Signature of other disposition	
45. Signature of other disposition		46. Signature of other disposition		47. Signature of other disposition		48. Signature of other disposition	
49. Signature of other disposition		50. Signature of other disposition		51. Signature of other disposition		52. Signature of other disposition	
53. Signature of other disposition		54. Signature of other disposition		55. Signature of other disposition		56. Signature of other disposition	
57. Signature of other disposition		58. Signature of other disposition		59. Signature of other disposition		60. Signature of other disposition	
61. Signature of other disposition		62. Signature of other disposition		63. Signature of other disposition		64. Signature of other disposition	
65. Signature of other disposition		66. Signature of other disposition		67. Signature of other disposition		68. Signature of other disposition	
69. Signature of other disposition		70. Signature of other disposition		71. Signature of other disposition		72. Signature of other disposition	
73. Signature of other disposition		74. Signature of other disposition		75. Signature of other disposition		76. Signature of other disposition	
77. Signature of other disposition		78. Signature of other disposition		79. Signature of other disposition		80. Signature of other disposition	
81. Signature of other disposition		82. Signature of other disposition		83. Signature of other disposition		84. Signature of other disposition	
85. Signature of other disposition		86. Signature of other disposition		87. Signature of other disposition		88. Signature of other disposition	
89. Signature of other disposition		90. Signature of other disposition		91. Signature of other disposition		92. Signature of other disposition	
93. Signature of other disposition		94. Signature of other disposition		95. Signature of other disposition		96. Signature of other disposition	
97. Signature of other disposition		98. Signature of other disposition		99. Signature of other disposition		100. Signature of other disposition	

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9158

BIRTH NO. 50-22510

1. NAME OF DECEASED
(Type or Print)

CAROLYN FOBES CANEDY

2. DATE
OF
DEATH

October 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Hospital for Women of Maryland

C. CITY OR TOWN

Ridgelywood

5200

D. STREET ADDRESS (If rural, give location)

Jopka Road

c. Length of stay in Baltimore

Yrs.
Mos.
Days

6. SEX

Female

7. COLOR OR RACE

W

8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

9. DATE OF BIRTH

October 20, 1950

10. AGE (in years last birthday)

11. Under 1 Year Months: Days

5

12. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hospital for Women of Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Malton Charles Canedy

14. MOTHER'S MAIDEN NAME

Margaret Ann Garrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mother

ADDRESS

Ridgelywood, Md.

18. 754.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive albuminosis, bilateral

DUE TO

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Defunct

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

1) congestive albuminosis; 2) post-surgical albuminosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-20-50 to 10-25, 1950 that I last saw the deceased alive on 10-25, 1950 and that death occurred at 1:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Louis D. Rocca

23B. ADDRESS

M. D. Hospital for the Women of

23C. DATE SIGNED

10-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

10/26/50

24C. NAME OF CEMETERY OR CREMATION LOCATION (City, town, or county)

Lansdown Park

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 25 1950

VS 150

1572



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9159**BIRTH No. **50 9159**
MO-22864

1. NAME OF DECEASED (Type or Print) Dominic Joseph Kinsley			2. DATE OF DEATH 10-24-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE		
B. FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hosp			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE		
c. Length of stay in Baltimore Yrs. 1 Mos. 8 Days 30			O. STREET ADDRESS (If rural, give location) APT 355 OAKLEE VILLAGE		
5. SEX MALE	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 10-23-50	9. AGE (In years last birthday) 1 8 30	11. BIRTHPLACE (State or foreign country) 1 8 30
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME James Richard Kinsley			14. MOTHER'S MAIDEN NAME MARY ROMANT		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		

18. 762.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) NEO-NATAL ASPHYXIA			CAUSE OF DEATH (A) NEO-NATAL ASPHYXIA DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-23 , 19 50 , to 10-24 , 19 50 ; that I last saw the deceased alive on 10-24 , 19 50 , and that death occurred at 2:30 p. m., from the causes and on the date stated above.					
23A. SIGNATURE Edward M. Reliak M. D.			23B. ADDRESS Bon Secours Hospital		23C. DATE SIGNED 10-25-50
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY Alexandria		24D. LOCATION (City, town, or county) (State) Baltimore Md	
DATE RECEIVED BY LOCAL REGISTRAR OCT 25 1950		REGISTRAR'S SIGNATURE W. J. Kennedy		25. FUNERAL DIRECTOR W. J. Kennedy ADDRESS Hollins 141	

100

100

UNITED STATES OF AMERICA
DEPARTMENT OF COMMERCE
BUREAU OF CUSTOMS

100

UNITED STATES OF AMERICA

DEPARTMENT OF COMMERCE

BUREAU OF CUSTOMS

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UNITED STATES OF AMERICA

DEPARTMENT OF COMMERCE

BUREAU OF CUSTOMS

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9160**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mrs. Mary Catherine Berlin

2. DATE

OF DEATH **Oct. 24, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1250 Cliftview Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Fe.

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Div.

8. DATE OF BIRTH

Dec. 12, 1915

9. AGE (In years last birthday)

34

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hwie.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Walter M. Ferdineline

14. MOTHER'S MAIDEN NAME

Emma E. Rotherhewer Fredk Co

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

220-07.5589

17. INFORMANT

ADDRESS

Emma E. Ferdineline Fredk Co

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Acute Myocardial Infarction

ANTECEDENT CAUSES

(B)

DUE TO

Coronary Thrombosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from 10/17/, 1950, to 10/24/, 1950, that I last saw the deceased alive on 10/24/, 1950, and that death occurred at 1:02 P.M. from the causes and on the date stated above.

23A. SIGNATURE

A. Andrew Pease

M. D.

23B. ADDRESS

1100 N. Caroline Street

23C. DATE SIGNED

10/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/27/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Olivet Cemetery

24D. LOCATION (City, town, or county)

Frederick

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

C. E. Clive & Son

0010

00

0010

THEATRE OF THE WORLD
HEATH OF STADIUM



50 9161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9161

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mabelle L. Michener

2. DATE
OF
DEATH

October 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

2702 Lyndhurst Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

15-09

D. STREET ADDRESS (If rural, give location)

2702 Lyndhurst Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

October 17, 1857

9. AGE (In years,
last birthday)

93

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

New York City, N. Y.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin Fairchild

14. MOTHER'S MAIDEN NAME

Calista Schaefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Mr. William Michener 925 Commonwealth Ave.
Boston, Massachusetts

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cardio vascular disease

since Sept 11,
1950

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) arterio sclerosis advanced

about
2 mos.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) pyelitis and cystitis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/11, 1950, Oct. 25, 1950 that I last saw the
deceased alive on Oct. 24, 1950, and that death occurred at 6 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

2220 Garrison Blvd.

23C. DATE SIGNED

Oct. 25, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

10-27-50

24C. NAME OF CEMETERY OR CREMATORY

Rock Creek Cemetery

24D. LOCATION (City, town, or county)

Washington, D. C.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 26 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

J. J. Schaefer & Sons

North & Anna Ave.
Baltimore - 17

VS 150

0932

Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. correct age is especially important. Physicians: write the causes of death clearly and legibly.

1988 02

1988 02

U.S. HOUSE OF REPRESENTATIVES

WILLIAM J. CLAY

101 KANGAS

BOND

CONGRESS

WATLEY

50 9162

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 9162

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Austin C. Sauer*2. DATE
OF
DEATH*Oct 23, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 25-04

D. STREET ADDRESS (If rural, give location)

519 Jeffrey St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*40 St Agnes Hospital*Yrs.
Mos.
Days

c. Length of stay in Baltimore

Life

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Nov 12, 1900

9. AGE (In years last birthday)

49

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR INDUSTRY

Coal & Oil (W)

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Werner Sauer

14. MOTHER'S MAIDEN NAME

Katherine Daubert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-09-2274

17. INFORMANT

ADDRESS

*Helen M. Sauer 519 Jeffrey St*18. *420.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

*Coronary arteriosclerotic*DUE TO *Heart Disease*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 7:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John J. Fisher

M. D.

23B. ADDRESS

St Agnes Hospital

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial**Oct 26-1950**Landon Park**Balto Md.*

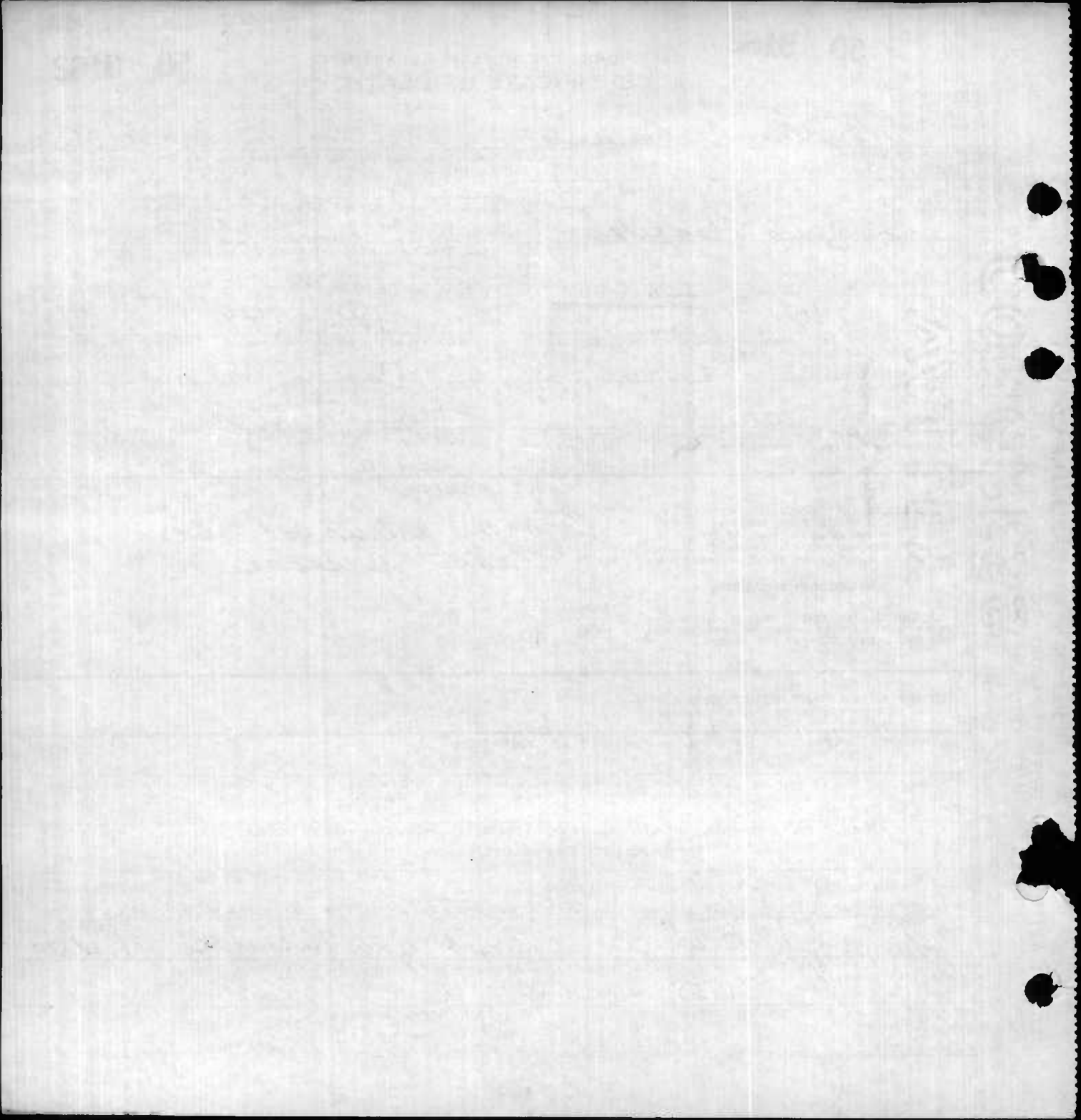
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Oct 26 1950**Edmondson Co**5311*



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Francis Bordenkircher

2. DATE
OF
DEATH

Oct 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Red. HLK 4E.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Okla

V-23

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Cleveland

D. STREET ADDRESS (If rural, give location)

310 W. Cherokee

c. Length of stay in Baltimore

8 days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Child

8. DATE OF BIRTH

4-28-1950

9. AGE (In years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

56 29

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR
INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

Okla

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Chas. R. Bordenkircher

14. MOTHER'S MAIDEN NAME

Virginia Doulds

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 754.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Congenital heart disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

10/25/50

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-18-1950 to 10-25-1950, that I last saw the
deceased alive on 10-25-1950, and that death occurred at 4:55 p.m. from the causes and on the date stated above.

23A. SIGNATURE

Lee W. Bass

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

REMOVAL

24B. DATE

10-26-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

CLEVELAND, OKLAHOMA

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950

George L. Schwab 2101 Frederick Ave.

1572

100

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M-650

50 9164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9164

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)*Ernest ~~Maroney~~ (MORONEY)*2. DATE
OF
DEATH*25 Oct 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Mercy Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 16-06

D. STREET ADDRESS (If rural, give location)

2834 Harlem St.

c. Length of stay in Baltimore

*LIFE*Yrs.
Mos.
Days

5. SEX

m

6. COLOR OR RACE

wh

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

Dec 20 1894

9. AGE (In years last birth day)

56

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

salesman

10B. KIND OF BUSINESS OR INDUSTRY

FUR OUTLET CO.

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Maroney

14. MOTHER'S MAIDEN NAME

Mary Hagerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

*unk.**NO.*

16. SOCIAL SECURITY NO.

214-03-1894

17. INFORMANT

Mrs. Sarah E. Berry - same

ADDRESS

18. *474X*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

1 wk.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

none

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

none

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *24 Oct.*, 19*50*, to *25 Oct.*, 19*50*, that I last saw the deceased alive on *25 Oct.*, 19*50*, and that death occurred at *3:45 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Lewler F. White

M. D.

23B. ADDRESS

Mercy Hosp.

23C. DATE SIGNED

25 Oct. 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

10-28-50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 26 1950

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

J. T. STANBURY 2700 EDMONDSON AVE

ADDRESS

VS 150

4906E

105

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

(VS 50-9164)

What was the cause underlying

the laryngeal obstruction ~~inflammation~~

See Document File 50-9164

11-14-50
CS

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) CLARENCE MELVIN PURDY			2. DATE OF DEATH OCTOBER 24, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 419 WINGATE ROAD		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH SEPTEMBER 26, 1861	9. AGE (in years last birthday) 89	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Financial Editor - Newspaper			11. BIRTHPLACE (State or foreign country) NEW YORK		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HORACE E. PURDY			14. MOTHER'S MAIDEN NAME PHOEBE GAGNUNG HAMMOND		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO. UNKNOWN		
17. INFORMANT MRS. W.H. ENGEL			ADDRESS 419 WINGATE ROAD, BALTIMORE		
18. 420.0 177X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) PULMONARY EDEMA DUE TO CEREBRAL HEMORRHAGE (B) MYOCARDIAL INFARCTION DUE TO Arteriosclerotic Heart Disease (C) _____ INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 4 DAYS 4 DAYS YEARS					
19. DATE OF OPERATION 0			19b. MAJOR FINDINGS OF OPERATION CARCINOMA OF PROSTATE		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from OCTOBER 20, 1950 , to OCTOBER 24, 1950 , that I last saw the deceased alive on OCTOBER 24, 1950 , and that death occurred at 9:05 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE W. P. Cox			23b. ADDRESS Union Memorial Hospital		
23c. DATE SIGNED 10-24-50					
24a. BURIAL, CREMA- TION, REMOVAL (Specify) Burial			24b. DATE 10/27/50		
24c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.			24d. LOCATION (City, town, or county) (State) Woodlawn, Md.		
DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1950			REGISTRAR'S SIGNATURE Wm. J. Sikes		
VS 150			FUNERAL DIRECTOR'S ADDRESS 0514 omh.		

MEDICAL CERTIFICATION

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20-0000

20-0000

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50 9166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9166

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

ALEXANDER M. RICH

2. DATE
OF
DEATH

Oct. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

2606 Talbot Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give
township)

Baltimore

28-03

D. STREET ADDRESS (If rural, give location)

2606 Talbot Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
widowed

8. DATE OF BIRTH

Feb. 11, 1862

9. AGE (In years
last birthday)

88

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Clergyman

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Rev. Arthur John Rich

14. MOTHER'S MAIDEN NAME

Fanny K. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

Mrs. S. Chaplin Davis 2606 Talbot Rd.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute congestive heart failure

DUE TO Arteriosclerotic cardio-vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO _____

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 11, 1949, to Oct. 24, 1950 that I last saw the
deceased alive on Oct. 24, 1950, and that death occurred at 7.30P.m., from the causes and on the date stated above.

23A. SIGNATURE

George A. Krupp

M. D.

23B. ADDRESS

3030 Edmondson Avenue

23C. DATE SIGNED

10/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/26/50

24C. NAME OF CEMETERY OR CREMATORY

All Saints Cem.

24D. LOCATION (City, town, or county)

Reisterstown, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950

VS 150

Wm. J. Dickens & Sons - Balto
Md.

093d

1970

1970

UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C. 20250

1970

UNITED STATES DEPARTMENT OF AGRICULTURE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

H-630 50 9167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9167

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Eubank Hart

2. DATE
OF
DEATH

October 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore Co.
C. CITY OR TOWN Towson

D. STREET ADDRESS (If rural, give location)

506 Baltimore Ave.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

August 6, 1892

9. AGE (In years last birthday)

58

If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Solicitor

10B. KIND OF BUSINESS OR INDUSTRY

Newspaper

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin Franklin Hart

14. MOTHER'S MAIDEN NAME

Sarah Cornelia Eubank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Yes

World War I

16. SOCIAL SECURITY NO.

231-14-8879

17. INFORMANT

Mrs. Bessie Hart

ADDRESS

506 Balto. Ave. Towson, Md.

18. 162X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic carcinoma of Rt lung.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) E. malnutrition
(C) ruptured bronchial stump post-op

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

October 17, 1950

19B. MAJOR FINDINGS OF OPERATION

Bronchogenic carcinoma, right lung

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from October 10, 1950, to October 24, 1950, that I last saw the deceased alive on Oct. 24, 1950, and that death occurred at 11:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. R. Shomer

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

10/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

Oct. 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

LODGE PARK CEM.

24D. LOCATION (City, town, or county)

BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR

OCT 26 1950

REGISTRAR'S SIGNATURE

H. R. Shomer

25. FUNERAL DIRECTOR

JOHN BURN'S SONS, TOWSON, MD.

ADDRESS

VS 150

490 4M

047C

50 8167

John Edward Hart

Maryland

Towson

John Memorial Hospital

August 6, 1942

Virginia

*Hospitals

2010

James M. Hart

1001 West 1st St. - Mr. James Hart

October 7, 1942

October 7, 1942

50 8167

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-630 50 9168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9168
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mr. Joseph Vincent Ward

2. DATE
OF
DEATH

Oct. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

Baltimore

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

505 W. Chesapeake Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Single

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

White

8. DATE OF BIRTH

SEPT. 13, 1908

9. AGE (In years last birthday)

42

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES WARD

14. MOTHER'S MAIDEN NAME

LORETTA OSBORNE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

NONE

ADDRESS

MRS. JAMES WARD, Towson, MD.

18. 541.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized purulent peritonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Perforated gastric duodenal ulcer.

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Oct. 12, 1950

19B. MAJOR FINDINGS OF OPERATION

Perforated duodenal ulcer

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/11/1950 to 10/23/1950, that I last saw the deceased alive on 10/23/1950, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

23A. SIGNATURE

B. J. J. J. J.

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

Oct. 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

MT. MORIAH CEMETERY

24D. LOCATION (City, town, or county)

Towson, MD.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JOHN BURNS' SONS, Towson, MD.

OCT 26 1950

VS-150

56424

1176

8310

02

8310

02

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of witness		11. Signature of funeral director		12. Signature of undertaker	
13. Signature of coroner		14. Signature of justice of the peace		15. Signature of health officer		16. Signature of police officer	
17. Signature of city clerk		18. Signature of city auditor		19. Signature of city treasurer		20. Signature of city engineer	
21. Signature of city assessor		22. Signature of city controller		23. Signature of city clerk		24. Signature of city auditor	
25. Signature of city treasurer		26. Signature of city engineer		27. Signature of city assessor		28. Signature of city controller	
29. Signature of city clerk		30. Signature of city auditor		31. Signature of city treasurer		32. Signature of city engineer	
33. Signature of city assessor		34. Signature of city controller		35. Signature of city clerk		36. Signature of city auditor	
37. Signature of city treasurer		38. Signature of city engineer		39. Signature of city assessor		40. Signature of city controller	
41. Signature of city clerk		42. Signature of city auditor		43. Signature of city treasurer		44. Signature of city engineer	
45. Signature of city assessor		46. Signature of city controller		47. Signature of city clerk		48. Signature of city auditor	
49. Signature of city treasurer		50. Signature of city engineer		51. Signature of city assessor		52. Signature of city controller	
53. Signature of city clerk		54. Signature of city auditor		55. Signature of city treasurer		56. Signature of city engineer	
57. Signature of city assessor		58. Signature of city controller		59. Signature of city clerk		60. Signature of city auditor	
61. Signature of city treasurer		62. Signature of city engineer		63. Signature of city assessor		64. Signature of city controller	
65. Signature of city clerk		66. Signature of city auditor		67. Signature of city treasurer		68. Signature of city engineer	
69. Signature of city assessor		70. Signature of city controller		71. Signature of city clerk		72. Signature of city auditor	
73. Signature of city treasurer		74. Signature of city engineer		75. Signature of city assessor		76. Signature of city controller	
77. Signature of city clerk		78. Signature of city auditor		79. Signature of city treasurer		80. Signature of city engineer	
81. Signature of city assessor		82. Signature of city controller		83. Signature of city clerk		84. Signature of city auditor	
85. Signature of city treasurer		86. Signature of city engineer		87. Signature of city assessor		88. Signature of city controller	
89. Signature of city clerk		90. Signature of city auditor		91. Signature of city treasurer		92. Signature of city engineer	
93. Signature of city assessor		94. Signature of city controller		95. Signature of city clerk		96. Signature of city auditor	
97. Signature of city treasurer		98. Signature of city engineer		99. Signature of city assessor		100. Signature of city controller	

50 9169 BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

50 9169
 Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Narry T. Deputy

2. DATE
OF
DEATH

10/24/50 6:40 a.m.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. 12-04

O. STREET ADDRESS (If rural, give location)

419 E. 22nd St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/1/1883

9. AGE (in years
last birthday)

67

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Gard Manager

10B. KIND OF BUSINESS OR
INDUSTRY

Oranda Oak (Co.)

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John L. Deputy

14. MOTHER'S MAIDEN NAME

Rose E. Beck

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-09-4863

17. INFORMANT

ADDRESS

Rheta W. Deputy 419 E. 22nd St

18.

181X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of bladder
DUE TO with metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHapprox.
6 mos.II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/20, 1950, to 10/24, 1950, that I last saw the deceased alive on 10/24, 1950, and that death occurred at 6:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. L. Deputy

23B. ADDRESS

11 W. 29th St.

23C. DATE SIGNED

10/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/27/50

24C. NAME OF CEMETERY OR CREMATORY

Old St. Pauls

24D. LOCATION (City, town, or county)

Kent Co. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10/26/1950

Wm. L. Deputy

Wm. Cook Inc. 1217 St. Paul St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9170

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS, Miss Naomi

2. DATE
OF
DEATH

Oct 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

35- Church Home & Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

8-04

D. STREET ADDRESS (If rural, give location)

1103 N. Patterson PK Ave

c. Length of stay in Baltimore

46 Years

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept 2, 1904

9. AGE (In years last birthday)

46

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Singer

10B. KIND OF BUSINESS OR INDUSTRY

Womans College of Md

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Adolph Thomas

14. MOTHER'S MAIDEN NAME

Clara Zeitler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Carla E. Thomas 1103 N. Pat. PK. Ave

18. 260X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Nephrotic Stage of

DUE TO

ANTECEDENT CAUSES

(B) Chronic Nephritis

DUE TO

10 Months

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Diabetes Mellitus

DUE TO

3 Years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/3, 1950, to 10/24, 1950, that I last saw the deceased alive on 10/24, 1950, and that death occurred at 5:42 P.M., from the causes and on the date stated above.

23A. SIGNATURE

H. Reed Carroll

M. D.

23B. ADDRESS

Church Home & Hospital

23C. DATE SIGNED

10/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/27/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

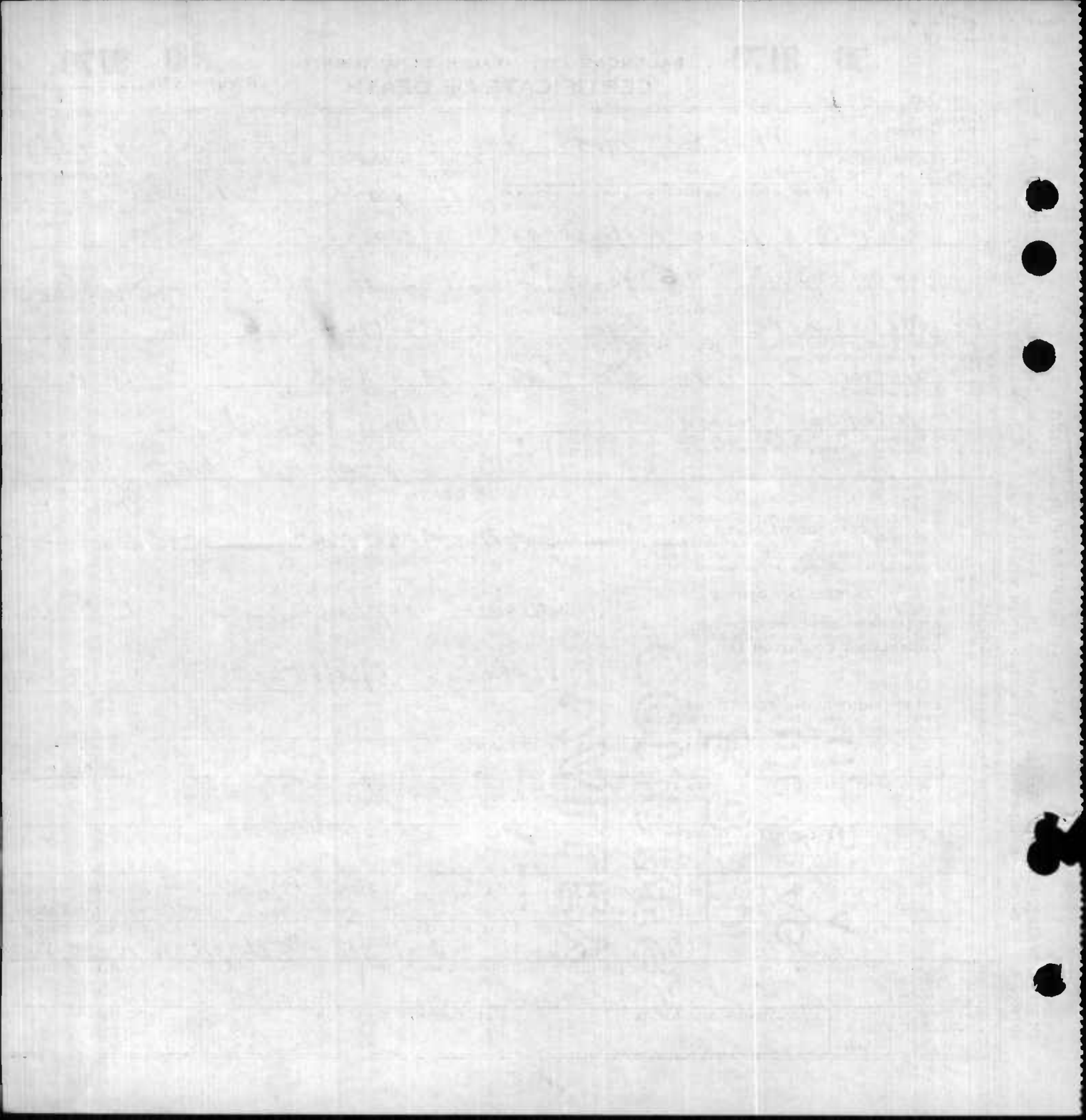
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950

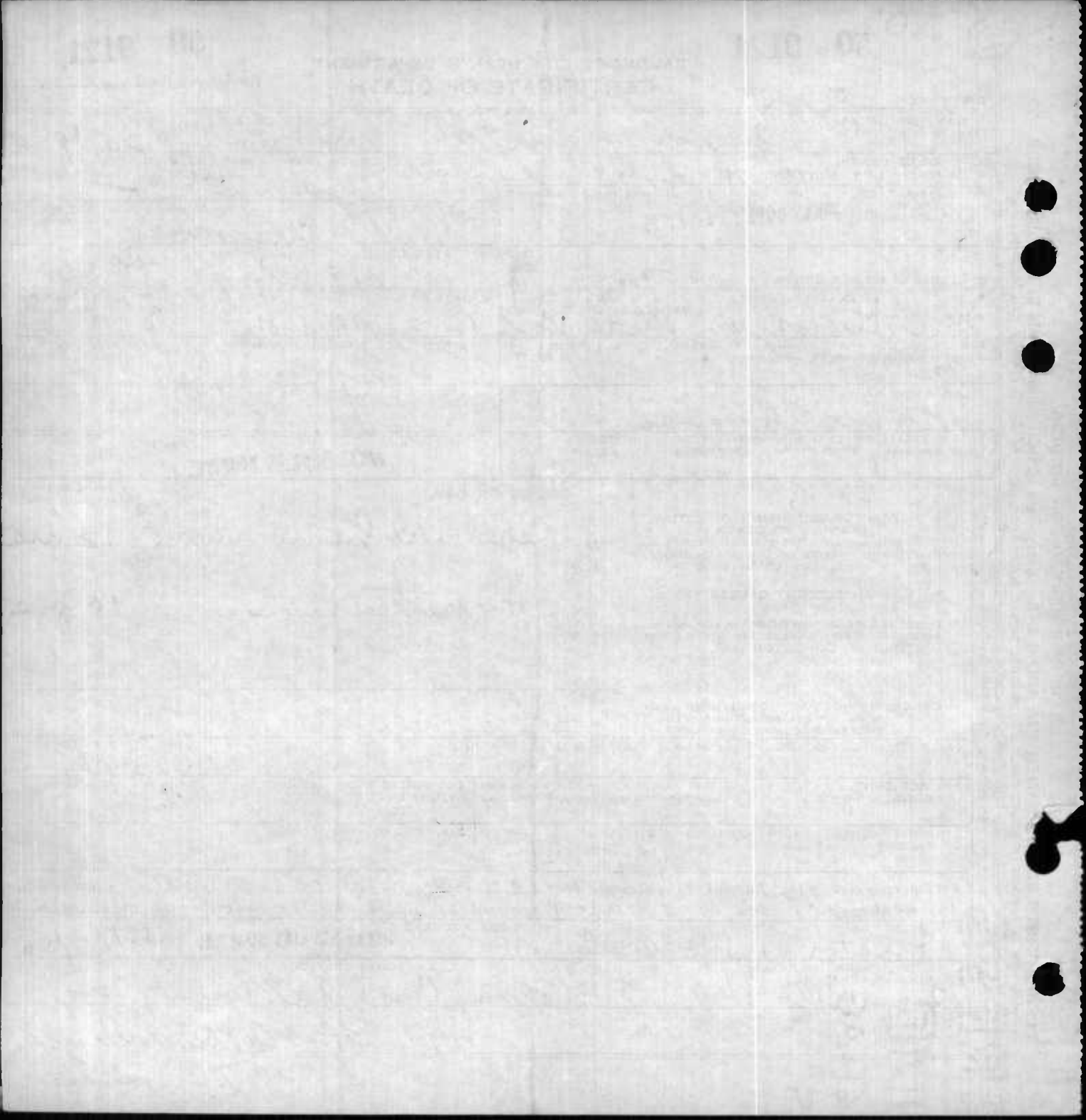
Wm Cook Inc. 1217 St. Paul St.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		John Smith		Oct 25, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE	
B. FULL NAME OF HOSPITAL OR INSTITUTION		Md		B. COUNTY	
Johns Hopkins Hospital		Baltimore		5-02	
C. CITY OR TOWN		D. STREET ADDRESS		(If rural, give location)	
Baltimore		418 Gough St.			
c. Length of stay in Baltimore		Yrs. Mos. Days			
25 mos					
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	H Under 1 Year Months: Days
Male	Colored	Married	12-25-1895	55	10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Banker				Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Moses Smith				?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
(If yes, give war or dates of service)				Johns Hopkins Hospital	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO		(A) Cerebral hemorrhage		12 hrs	
ANTECEDENT CAUSES		(B) Hypertension		10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-25-1950 to 10-25-1950, that I last saw the deceased alive on 10-25-1950, and that death occurred at 8 a.m., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Victor G. McKusick M.D.		Johns Hopkins Hospital		10/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Oct. 29/50		Mt. Calvary Cem	
24D. LOCATION (City, town, or county)		24E. LOCATION (City, town, or county)		24F. LOCATION (City, town, or county)	
G.A. County Md		G.A. County Md		G.A. County Md	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
Oct 20 1950		[Signature]		Mrs. Robert G. Elliott Daughter	



E-250 50 9172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9172
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

TIEHIE EISEN

2. DATE
OF
DEATH

10-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 4613 Park Heights

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION

Mt Sinai Home

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

40 Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

3117 Modawumme Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Female

White

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

Russia

13. FATHER'S NAME

Isaac

14. MOTHER'S MAIDEN NAME

Styren

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Ester Kessel - Same

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Lobar Pneumonia 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive cardio-vasc. dis. 15-20 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK

NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from Oct. 23, 1950, to Oct. 24, 1950, that I last saw the deceased alive on Oct. 25, 1950, and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Heriman Seidel

23B. ADDRESS

2404 Entaw Pl

23C. DATE SIGNED

Oct. 26-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950
VS 150

JACK T. Lewis

JACK T. Lewis

2100 Entaw Pl

108.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Seidel

STRE 00

1913

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1913

50 9173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9173

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

SAMUEL MYERSON

2. DATE
OF
DEATH

10-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2476 Shurday Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mt Carmel Home

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1230 Park Heights Ave

c. Length of stay in Baltimore

46

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (in years less birthday)

74

H Under 1 Year

Months: Days

H Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired CONST

10B. KIND OF BUSINESS OR INDUSTRY

Brick Layer

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not known

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Ruth Myerson -

ADDRESS

Same

18. 422.2 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) ...

DUE TO

(B) ...

DUE TO

(C) ...

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Edema of lungs
Chronic myocarditis

INTERVAL BETWEEN ONSET AND DEATH

2 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949 to 1950, that I last saw the deceased alive on 10/15/50, and that death occurred at 7:10 P.M., from the causes and on the date stated above.

23A. SIGNATURE

W. J. Bauman

M. O.

23B. ADDRESS

2040 Eastern Pl

23C. DATE SIGNED

10/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-26-50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county)

Balto Md

DATE RECEIVED BY LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

W. J. Bauman

25. FUNERAL DIRECTOR

Jack Lewis 2100 Eastern Pl

ADDRESS

VS 150

504 24

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

THE UNIVERSITY

OF CALIFORNIA

LIBRARY

PHYSICS

DEPARTMENT

OF PHYSICS

UNIVERSITY OF CALIFORNIA

LIBRARY

PHYSICS

DEPARTMENT

OF PHYSICS

UNIVERSITY OF CALIFORNIA

LIBRARY

PHYSICS

DEPARTMENT

OF PHYSICS

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LIBRARY

PHYSICS

DEPARTMENT

OF PHYSICS

50 9174

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9174

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HANS CARL MOOSHAGE

2. DATE
OF
DEATH

Oct. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTEUS Marine Hospital
Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Pa.

B. COUNTY

V-35

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
PhiladelphiaD. STREET ADDRESS (If rural, give location)
909 Carlisle St.

c. Length of stay in Baltimore

47 days

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

5/17/90

9. AGE (In years
last birthday)

60

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

AB seaman

10B. KIND OF BUSINESS OR
INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Carl Mooshage

14. MOTHER'S MAIDEN NAME

Maria ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, oo or ockown) (If yes, give war or dates of service)

?

16. SOCIAL
SECURITY NO.
216-12-8513

17. INFORMANT

ADDRESS

Records-US Marine Hospital, Balto, Md.

18. 157X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of pancreas with
carcinomatosis

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from Sept. 5, 1950, to Oct. 22, 1950 that I last saw the
deceased alive on Oct. 22, 1950, and that death occurred at 10:45 PM, from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10-26-50

Mt. Carmel

Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950

William Williams, Jr.

Lilly & Zinke

403 S. Wolfe Street

VS 150

673 5510

0469

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00

1-1-1

0

10-27-20

10-27-20

10-27-20

10-27-20

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Edward Parker Smith*2. DATE
OF
DEATH*Oct. 22, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*00**502 W. Mechen St.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 14-02

D. STREET ADDRESS (If rural, give location)

502 W. Mechen St.

c. Length of stay in Baltimore

40 yrs.

5. SEX

Male

6. COLOR OR RACE

*Colored*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Widower*

8. DATE OF BIRTH

March 12, 1855

9. AGE (In years last birthday)

*95*10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Trainer

10B. KIND OF BUSINESS OR INDUSTRY

Race Horses

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edward Smith

14. MOTHER'S MAIDEN NAME

*Unknown*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

Home

17. INFORMANT

ADDRESS

*Mrs. Rosie Cars 1206 Loring St.*18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Coronary Thrombosis**1 day*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

*Myocarditis
Hypertension*

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senility

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/20*, 1950, to *10/22*, 1950, that I last saw the deceased alive on *10/22*, 1950, and that death occurred at *3:30 P* m., from the causes and on the date stated above.

23A. SIGNATURE

Alfred R. Lafont

M. D.

23B. ADDRESS

822 N. B. Moser

23C. DATE SIGNED

10/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 26, 1950

24C. NAME OF CEMETERY OR CREMATORY

Achutan Mem. Pk.

24D. LOCATION (City, town, or county)

Baltimore C. Ind.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Funeral Home 1651 Druid Hill Ave.

50 8130

50 8130



CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <i>Ernest L. Alston</i>		2. DATE OF DEATH <i>Oct. 24, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2517 W. Cullow St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 13-03</i>			
c. Length of stay in Baltimore <i>31 years</i>		D. STREET ADDRESS (If rural, give location) <i>2517 W. Cullow St.</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 17, 1890</i>	9. AGE (in years last birthday) <i>60</i>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Master</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Public Rest.</i>		11. BIRTHPLACE (State or foreign country) <i>Mississippi</i>	
13. FATHER'S NAME <i>Charles Alston</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Jordan</i>		12. CITIZEN OF WHAT COUNTRY? _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT <i>Althea W. Alston W. Cullow St.</i>	

1B. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Hypertension Cerebrovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO _____			
(C) _____ DUE TO _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>January 1, 1950</i> to <i>Oct 24, 1950</i> , that I last saw the deceased alive on <i>11/30</i> , 19 <i>50</i> , and that death occurred at <i>11:30 PM</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Deen Harris</i>		23B. ADDRESS <i>1702 N. Carleith</i>		23C. DATE SIGNED <i>10/25/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct. 27, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>W. Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25. FUNERAL DIRECTOR <i>Wm. J. Williams, Inc.</i>		ADDRESS <i>1601 Wm. J. Williams, Inc.</i>	

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Susan Holiday*2. DATE
OF
DEATH*Oct. 24, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

*Maryland*B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 27-18

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

5321 Denmore Ave.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)If Under 1 Year
Months; DaysIf Under 24 Hours
Hours; Min.*Female**Colored**Widow**June 14, 1894**56*10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?*Domestic**Ret. family**Baltimore Co. Md.**USA*

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

*Elijah Quickley**Annie Quickley*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs. Follie Dickerson K. Stricker St.*18. *422.1*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) *Cardiovascular Dis.*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Gen. Arteriosclerosis*

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Sept*, 1950, to *24 Oct*, 1950, that I last saw the
deceased alive on *24 Oct*, 1950, and that death occurred at *845pm.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

B M R. Reed

M. D.

*1215 Madison Ave**25 OCT 1950*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

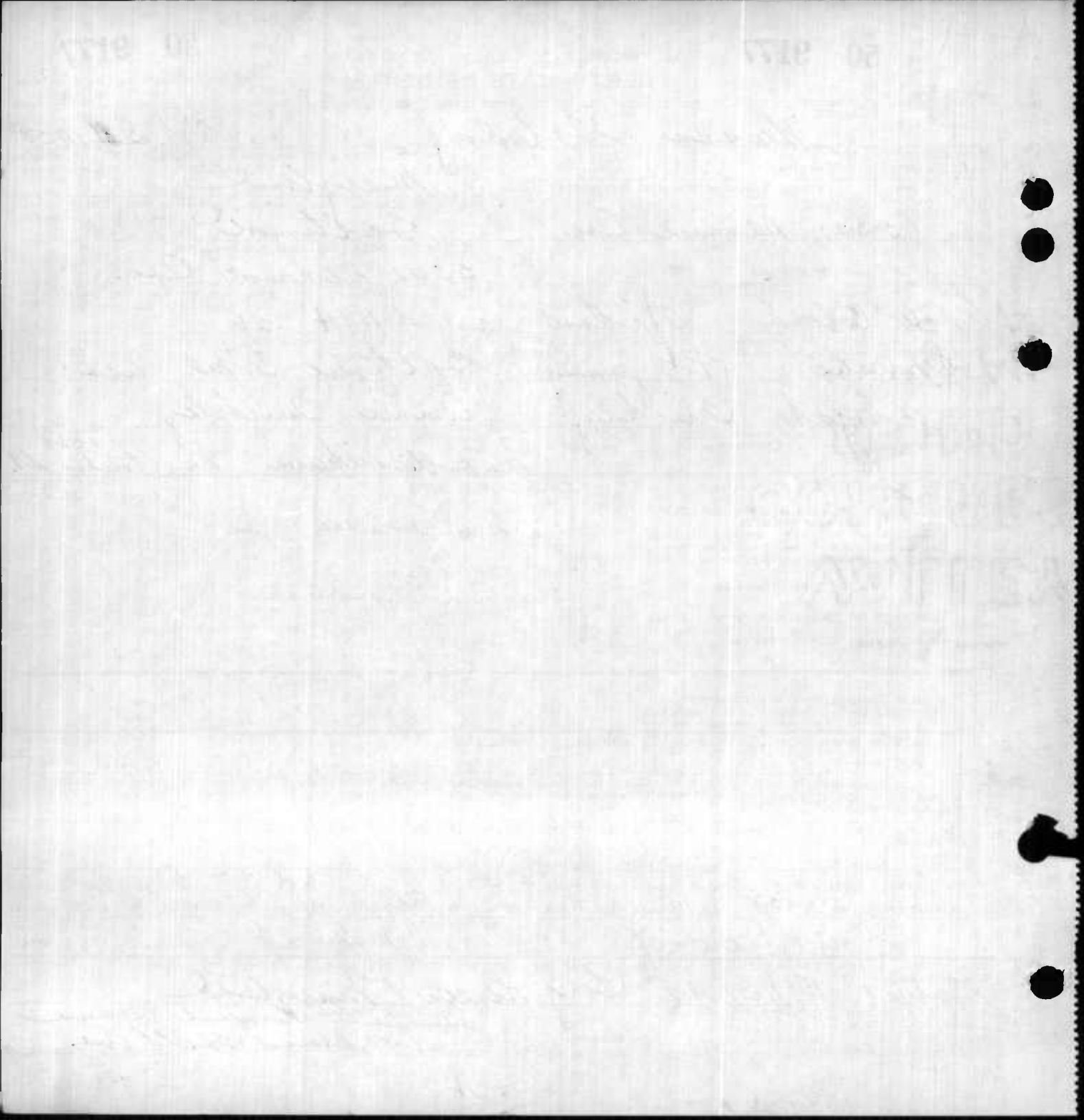
*Burial**Oct. 28, 1950**Long Green, Maryland*DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*OCT 26 1950**Wilmington, Delaware**Wilmington Funeral Home*
1633 Cornhill Hill Ave



50 9178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9178

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WESLEY

COX

2. DATE
OF
DEATH

Oct. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTIONFound in harbor foot of
BroadwayYrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 5-01D. STREET ADDRESS (If rural, give location)
418 N. Caroline St.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

Oct. 14, 1918

9. AGE (In years
last birthday)

32

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
General Farm Hand10B. KIND OF BUSINESS OR
INDUSTRY11. BIRTHPLACE (State or foreign country)
Buckingham Co., Virginia12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Whiley Cox

14. MOTHER'S MAIDEN NAME

Susie Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W. W. II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Susie Stokes

18. E929.8

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Drowning *

DUE TO subdural hematoma and fracture of skull

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
*UNDERLYING * & CONTRIB-
UTING * CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)
*Harbor -- Sidewalk21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? *Found-Harbor Ft. Broadway
418 N. Bond Street 2-321D. TIME (Month) (Day) (Year) (Hour)
OF INJURY *Found-10-23-50 2PM
October 7, 1950 ? P m.21E. INJURY OCCURRED
WHILE AT NOT WHILE
WORK ☐ AT WORK ☒21F. HOW DID INJURY OCCUR? *Found drowned --
Slipped and fell to sidewalk22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. S. Fisher

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....23C. DATE SIGNED
10-26-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial24B. DATE
10/26/5024C. NAME OF CEMETERY OR CREMATORY
Baltimore National Cm.24D. LOCATION (City, town, or county) (State)
Baltimore, MarylandDATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

V S 151

N 990X

OVER 820101129 N. Caroline St. 183

8-10 18-2 Fracture Skull about 1 week before death
Fracture not found by doctor at 8:00 A.M.
Discharged from Hospital - 1 week later found
Drowned -
History from Medical Examiner's
office

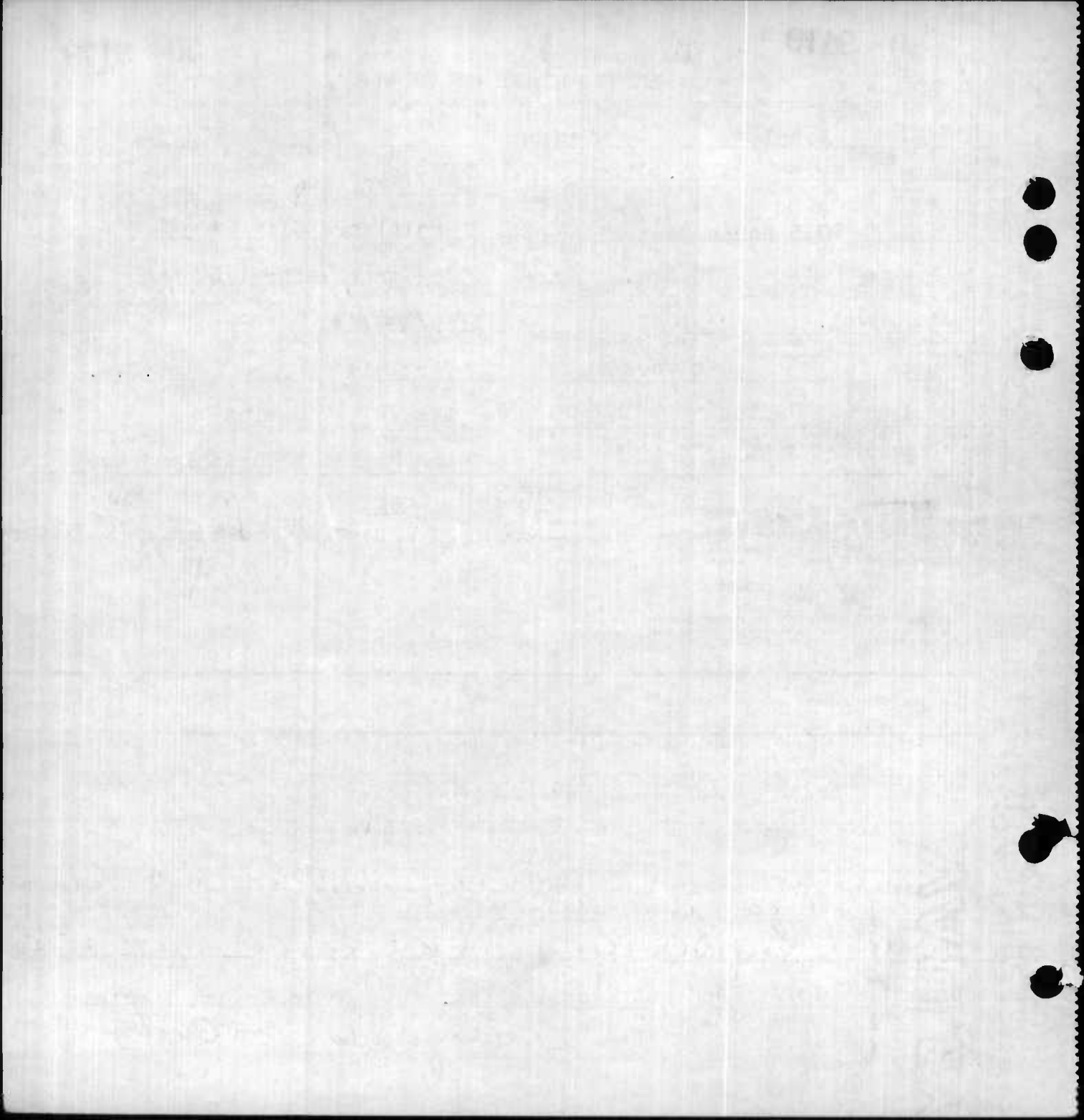
8-10-2

to H. H. B. A. Hall
H. H. B. A. Hall

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9179
Registered No. _____

BIRTH NO. 512		1. NAME OF DECEASED (Type or Print) Pearl Simpson		2. DATE OF DEATH 10/23/1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1015 North Central Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 10-01		
c. Length of stay in Baltimore 10 Yrs.			D. STREET ADDRESS (If rural, give location) 1015 North Central Avenue		
5. SEX Female	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 11/15/1910	9. AGE (in years last birthday) 39	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mosley Hamlet			14. MOTHER'S MAIDEN NAME Ida Hamlet		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Edward Hamlet 1236 Ashland Ave		

18. 730.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Bacteriemia - Rt. Leg DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 15 mos
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 10-1-1950 to 10-23-1950, that I last saw the deceased alive on 10-23-1950, and that death occurred at 3A m., from the causes and on the date stated above.				
23A. SIGNATURE Wm. L. Ray Berry M.D.		23B. ADDRESS 1420 E. Chase		23C. DATE SIGNED 10-25-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/29/1950	24C. NAME OF CEMETERY OR CREMATORY St Michales Cem.	24D. LOCATION (City, town, or county) (State) Drake Branch Virginia	
DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR ADDRESS Elroy G. Wilson 1000 Brantly Ave		



N.D.128354

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9180

BALTIMORE CITY HEALTH DEPARTMENT

50

9180

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Cora Johnson

2. DATE
OF
DEATH

Oct. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR
INSTITUTION

Baltimore City Hospital

4940 Eastern Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

No Home

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Nov. 25, 1875

9. AGE (In years

last birthday)

74

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ruben Garrett

14. MOTHER'S MAIDEN NAME

Margaret Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B.C.H. 4940 Eastern Avenue

18. 260 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Broncho- pneumonia

DUE TO

10 days

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

20-30 Yrs.

19A. DATE OF OPERATION

4-27-49, 4-22-49, 8-3-50

19B. MAJOR FINDINGS OF OPERATION

Bilateral Mature Senile Cataracts, Diabetic Gangrene

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-19, 1949, to 10-21, 1950, that I last saw the
deceased alive on 10-21, 1950, and that death occurred at 9 P. M., from the causes and on the date stated above.

23A. SIGNATURE

J. B. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-24-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Mt. Auburn Cem.

Brooklyn Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950

J. B. Rogers

Chas. G. Wilson, Mrs. Buntz

VS 150

061.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CHIP 106

DATE 10

CERTIFICATE OF DEATH



50 9181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9181

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS EMMETT GUNTER

2. DATE
OF
DEATH

Oct. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR US Marine Hospital

INSTITUTION Wyman Pk. Drive & 31st St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

4-01

D. STREET ADDRESS (If rural, give location)

122 Market Place

c. Length of stay in Baltimore

29 days

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

11/4/98

9. AGE (In years last birthday)

51 52

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Gunter

14. MOTHER'S MAIDEN NAME

Sarah Rowan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

?

16. SOCIAL SECURITY NO.

?

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18. 002X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis bilateral, advanced

DUE TO

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Ulcerous thrombosis iliac, bilateral

DUE TO

Unknown

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Sept. 25, 1950, to Oct. 24, 1950, that I last saw the deceased alive on Oct. 24, 1950, and that death occurred at 7:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

10/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct-27-50

24C. NAME OF CEMETERY OR CREMATORY

St. Peter & Pauls

24D. LOCATION (City, town, or county)

Cumberland - Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 26 1950

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Earl B. Wolcott 403-E-25-51

ADDRESS

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UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE

1951

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M-254

50 9182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9182
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Ophelia Mc Millan		Oct 24, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
b. FULL NAME OF HOSPITAL OR INSTITUTION		a. STATE			
1443 n. Fulton ave		c. CITY OR TOWN (If outside corporate limits, write full L and give township)			
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location)			
23 years.		1443 n. Fulton ave			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months: Days
7	C		Dec 15, 1923	26	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Worker Clerk		Social Security		n.e.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Samuel Mc Millan		Hattie Buie		U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Hattie Mc Millan	
				ADDRESS	
				1443 n. Fulton ave	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
002X I		Pulmonary tuberculosis			
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/15-1950, to 10/24, 1950 that I last saw the deceased alive on 10/24, 1950 and that death occurred at m., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Burke		213478		10/26/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10-27-50		arbitus	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR		ADDRESS	
Baltimore		Geo. S. Nelson		1303 Presstman st	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE			
OCT 26 1950		[Signature]			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

MURRAY
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9183

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Thomas H. Murray*2. DATE
OF
DEATH*10/23/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION*Provident Hospital*4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE*Maryland*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write P.O. and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

704 W. Mulberry St

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

*C*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

*June 30, 1900*9. AGE (In years
last birthday)*50*If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Janitor*10B. KIND OF BUSINESS OR
INDUSTRY*Davis Chemical Co*

11. BIRTHPLACE (State or foreign country)

*(M) Baltimore*12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas H. Murray Sr.

14. MOTHER'S MAIDEN NAME

*Eliza Smith*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)*No*16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Edna Murray 704 W. Mulberry St

18.

153X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

*Carcinoma of colon*INTERVAL BETWEEN
ONSET AND DEATH*July 1950*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

October 1950

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *October 21, 1950*, to *October 23, 1950*, that I last saw the
deceased alive on *October 23, 1950*, and that death occurred at *12:37 m.*, from the causes and on the date stated above.

23A. SIGNATURE

A. Nicolas

M. D.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

*10/23/50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)*Burial*

24B. DATE

10-26-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Balto.

(State)

*Md.*DATE RECEIVED BY
LOCAL REGISTRAR*OCT 26 1950*

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

Wm. H. Williams

ADDRESS

322 W. Schroeder St

1912

1912



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9184

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Stanislaus Malinowski</i>			2. DATE OF DEATH <i>Oct 25-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>3523 Toone St.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> <i>2-03</i>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>602 S Linn Street</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3-20-1871</i>	9. AGE (In years last birthday) <i>79</i> If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labr.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>General Labor</i>	11. BIRTHPLACE (State or foreign country) <i>Poland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Malinowski</i>			14. MOTHER'S MAIDEN NAME <i>Leofila Malkinaka</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT ADDRESS <i>Mitchell Wrenick 357 S Drew St</i>		

18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hypertensive Cardiac Vascular.</i> DUE TO (A) _____	CAUSE OF DEATH <i>Cardiac Failure</i> DUE TO (B) _____	INTERVAL BETWEEN ONSET AND DEATH _____
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from *June*, 19*49*, to *Oct 25*, 19*50*, that I last saw the deceased alive on *Oct 25*, 19*50*, and that death occurred at *12 45* m., from the causes and on the date stated above.

23A. SIGNATURE *Michal Janowski* M.D. 23B. ADDRESS *2711 Eastern Ave* 23C. DATE SIGNED *Oct 25, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct 25-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus</i>	24D. LOCATION (City, town, or county) (State) <i>Balto City Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 26 1950</i>		25. FUNERAL DIRECTOR ADDRESS <i>1707 Eastern Ave</i>	

50 2184

50 2184



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 9185**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) **JOSEPH PROTZON**

2. DATE OF DEATH **October 25, 1950**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION
South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

C. Length of stay in Baltimore
Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)
1605 Light Street

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

H Under 1 Year Months Days

I Under 24 Hours Hours Min.

male white married

Aug. 1897 53

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Brakeman

B. & O. R. R. Co.

Poland

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Conrad Protzon

Eve Kycia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

yes

158-05-1095

Irene Kafura, 7022 Ridge Boulevard, Brooklyn, N.Y. 11214

18. **E800X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Crushing injuries of chest and abdomen**

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
coal pier

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
B & O Railroad Coal Pier, Curtis Bay

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
October 25, 1950 11.30 a.m.

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?
Fell off train platform and was run over

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Samuel S. Fisher

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED
Oct. 26, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)
removal

24B. DATE
10/27/50

24C. NAME OF CEMETERY OR CREMATORY
Jersey City

24D. LOCATION (City, town, or county) (State)
Jersey City, New Jersey

DATE RECEIVED BY LOCAL REGISTRAR
OCT 26 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

169.0

62450

1217 St. Paul Street

VS 151

N-862.2

169.0

✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1998

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9186

Registered No. _____

50 9186

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) AMELIA S. APPEL			2. DATE OF DEATH October 25, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 3020 E. Pratt St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION _____			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-00		
C. Length of stay in Baltimore life Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 3020 E. Pratt St.		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug. 5, 1865	9. AGE (In years last birthday) 85	10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Charles Coleman			14. MOTHER'S MAIDEN NAME Margaret Adrian		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT ADDRESS Wm. M. Appel, husband, above		

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) arteriosclerotic cardio	DUE TO	20 yrs.
	(B) acute congestive failure and pneumonia	DUE TO	4 days
	(C) senility	DUE TO	

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 1 , 19 50 , to Oct 25 , 19 50 , that I last saw the deceased alive on Oct 24 , 19 50 , and that death occurred at 8:00 Am. , from the causes and on the date stated above.					
23A. SIGNATURE Benton U. Lock MD		23B. ADDRESS 2934 E. Balto. St.		23C. DATE SIGNED 10/26/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct.		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25. FUNERAL DIRECTOR Schulzke Funeral Home, Inc. 2601-325 E. Madison St.			
DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1950		REGISTRAR'S SIGNATURE [Signature]		ADDRESS	

093d

1810 06

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA
IN RE: THE ESTATE OF

1810 06

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9187**

BIRTH NO. **50 9187**

1. NAME OF DECEASED (Type or Print) Mr. Earl Hayes			2. DATE OF DEATH 10-25-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION Don Secours Hospital. location)			C. CITY OR TOWN (If outside corporate limits, give full name and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 4508 Harble Hall Rd.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1-18-09	9. AGE (In years last birthday) 41	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver-Salesman			10B. KIND OF BUSINESS OR INDUSTRY American Brewery		11. BIRTHPLACE (State or foreign country) Bal. Md.
13. FATHER'S NAME Frederick Hayes			14. MOTHER'S MAIDEN NAME Vola Finagi		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 216-01-1974	17. INFORMANT ADDRESS Ethel Hayes, wife, above		

18. 446x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) Acute pulmonary edema. DUE TO Uremia.		
	(B) Arterial hypertension. DUE TO Nephrosclerosis.		
(C)			

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 17 , 19 50 to Oct 25 , 19 50 that I last saw the deceased alive on Oct 25 , 19 50 , and that death occurred at 12:40 p.m., from the causes and on the date stated above.					
23A. SIGNATURE R. J. J. J.		23B. ADDRESS Don Secours Hospital		23C. DATE SIGNED 10-25-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 28, 1950		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) 3310 Taylor Ave., Baltimore					
DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR ADDRESS Schimmeler Funeral Home, Inc. 2601-3-5 E. Madison St.	

50 2187

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

50 2187



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9188
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILHELMINA SIEGMAN		2. DATE OF DEATH Oct. 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore life		D. STREET ADDRESS (If rural, give location) 539 N. Luzerne Ave.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) divorced	8. DATE OF BIRTH Feb. 18, 1884
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marker		10B. KIND OF BUSINESS OR INDUSTRY Julius Gutman & Co.	9. AGE (In years last birthday) 66
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Berthold Schell		14. MOTHER'S MAIDEN NAME Charlotte Bast	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-20-217	
17. INFORMANT Charlotte Schell, sister, above		ADDRESS	

18. **E820.7**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Fracture of pelvis with crushing injury of abdomen and left thigh**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Fayette and Luzerne Sts.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
Oct. 24, 1950 6 P.M.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?
purse caught in bus door and deceased was dragged on street

22. I certify that I took charge of the remains described above, held an **Inspection & Inq.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

[Signature]

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐

23C. DATE SIGNED
Oct. 25, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE
Oct. 27, 1950

24C. NAME OF CEMETERY OR CREMATORY
Baltimore Cem.

24D. LOCATION (City, town, or county) (State)
North Ave. & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home, Inc.
2801-555 E. Madison St.

V S 151

N-808.2

6904G

170C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

S-316
50 9189BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9189
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John F. Stafford</i>		2. DATE OF DEATH <i>Oct. 24, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>4723 Delaware Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Ind</i> B. COUNTY <i>Balto.</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore</i> <i>27-16</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>4723 Delaware Ave</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>March 10, 1873</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cement</i>	9. AGE (In years last birthday) <i>77</i>
11. FATHER'S NAME <i>John F. Stafford</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <i>Annie Maloney</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Alice M. Stafford</i>	
		ADDRESS <i>4723 Delaware Ave</i>	

18. <i>4723</i> <i>154X</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>myocarditis</i> DUE TO	<i>June 1, 1948</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>C. H. y Return</i> DUE TO	<i>Feb. 1950</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) <i>> C. H. y Return</i>	<i>Feb. 1950</i>

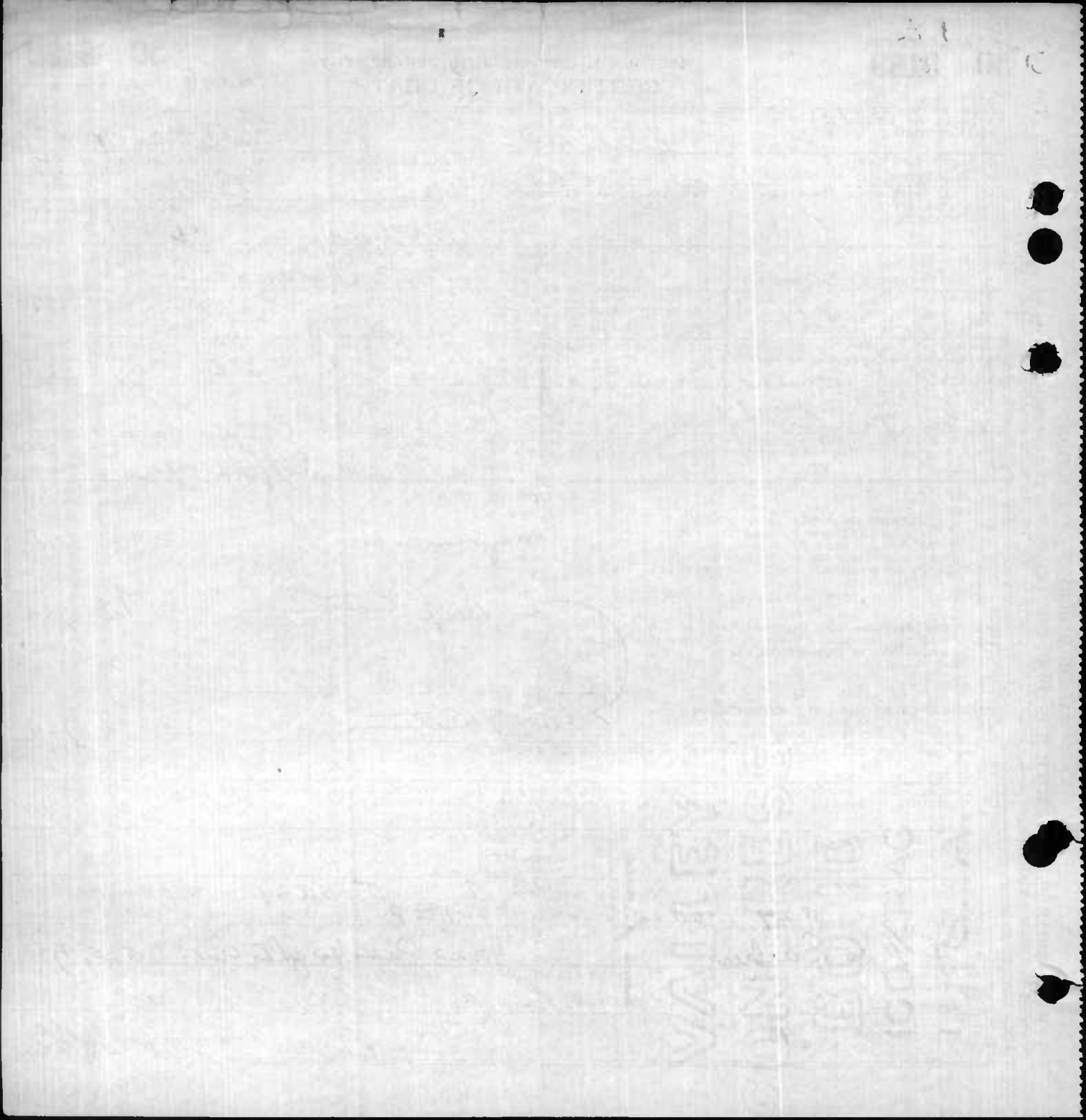
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 7</i> , 19 <i>48</i> , to <i>Oct 24</i> , 1950, that I last saw the deceased alive on <i>Oct 24</i> , 1950, and that death occurred at <i>11:45</i> p.m., from the causes and on the date stated above.				
23A. SIGNATURE <i>F. J. Barber</i>		23B. ADDRESS <i>4723 Park Heights Ave.</i>	23C. DATE SIGNED <i>Oct 25, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 27/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Trinity Ridge</i>	24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 26 1950</i>		REGISTRAR'S SIGNATURE <i>Loring Byers</i>		25. FUNERAL DIRECTOR <i>Loring Byers</i>
		ADDRESS <i>5005 Park Heights Ave.</i>		

VS 150

046d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



F-655
50 9190BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9190

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mr. FRANK W. FAIRMAN

2. DATE
OF
DEATH

10-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. Md.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY
U.S.A. Md.

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution)

Bon Secours Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

203 N. Allendale St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

1-3-67

9. AGE (In years
last birthday)

83

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknowns) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Egell 2017 Allendale St.

18.

150X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Inanition

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B) Cancer of esophagus

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10-18-50

19B. MAJOR FINDINGS OF OPERATION

Cancer of esophagus

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 11, 1950, to Oct. 25, 1950, that I last saw the
deceased alive on 10-11, 1950, and that death occurred at 12:50 m., from the causes and on the date stated above.

23A. SIGNATURE

M. D. M. D.

23B. ADDRESS

2025 W. Fayette St.

23C. DATE SIGNED

10-25-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Oct 27/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Airy

24D. LOCATION (City, town, or county) (State)

Baltimore Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950

M. D. M. D.

Mama C. Syfer

1600 N. North Ave.

0018 02

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF STAFF

0018 02

0018 02

UNITED STATES DEPARTMENT OF THE ARMY

0018 02



PLEASE WRITE IN INK. Every item of information should be applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F-324
50 9191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9191

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ETZEL, William F.

2. DATE
OF
DEATH

Oct 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

Baltimore 27-02

D. STREET ADDRESS (If rural, give location)

4612 Harford Rd

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Apr. 23-1872

9. AGE (In years last birthday)

78

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Refined Foreman Gas Meter Rep Shop

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Egid Etzel

14. MOTHER'S MAIDEN NAME

Caroline Hohler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary C. Debes - 5311 Catalpha

18. 002 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Malignant Tuberculosis

DUE TO

of about 2 weeks duration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

over

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Generalized Arterio Sclerosis

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-23-1950 to Oct 25, 1950, that I last saw the deceased alive on Oct 24 1950, and that death occurred at 5:30 Am., from the causes and on the date stated above.

23A. SIGNATURE

Elmer W. Demarest M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

10-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/28/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balto Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 26 1950

REGISTRAR'S SIGNATURE

Elmer W. Demarest

25. FUNERAL DIRECTOR

L. J. Luck - 5305 Harford Rd

ADDRESS

VS 150

13B

Lungs involved. Information obtained from Bureau of Tuberculosis
report card. 2/1/51.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9192

BIRTH NO. 50 9192

1. NAME OF DECEASED
(Type or Print)

Allen H. Heller

2. DATE
OF
DEATH

10/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 27-06

c. Length of stay in Baltimore

60

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

5301 Hamlet Ave

5. SEX

M

6. COLOR OR RACE

Wht

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

5/12/1867

9. AGE (In years
last birthday)

83

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired Receiving Ex.

10B. KIND OF BUSINESS OR
INDUSTRY

Retail - N.K.Co.

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Rubin Heller

14. MOTHER'S MAIDEN NAME

Susanna Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

Ethel Minor

ADDRESS

same

18.

420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute Myocardial Infarction

13 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/24, 1950, to 10/25, 1950, that I last saw the
deceased alive on 10/25, 1950, and that death occurred at 1 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Paul F. Richardson

M. D.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

10/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

10/27/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

Balto Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William M. Williams

25. FUNERAL DIRECTOR

L. J. Luck

ADDRESS

5305 Harford Rd



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9193**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)**WILLIAM JOHN GARRITY**2. DATE
OF
DEATH**Oct. 24, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR
INSTITUTION location)**3337 Ravenwood Avenue**

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3337 Ravenwood Avenuec. Length of stay in Baltimore **Life**Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)**Married**

8. DATE OF BIRTH

May 1, 18989. AGE (in years
last birthday)**52**

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)**Handyman**10B. KIND OF BUSINESS OR
INDUSTRY**Hardware supplies**

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.12. CITIZEN OF
WHAT COUNTRY?**USA**

13. FATHER'S NAME

Bernard W. Garrity

14. MOTHER'S MAIDEN NAME

Elizabeth Kelchenstein15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.**216-05-0074**17. INFORMANT **3337 Ravenwood Avenue**
ADDRESS**Mrs. Lena B. Garrity**

18.

470.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) **Acute myocardial Infarction****10 minutes**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) **Arterio-sclerotic cardio-
vascular Disease**

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-9-**, 19**40** to **10-5-50**, that I last saw the
deceased alive on **10-5-**, 19**50**, and that death occurred at **6 P.** m., from the causes and on the date stated above.

23A. SIGNATURE

William C. Lang

23B. ADDRESS

2117 Belair Rd

23C. DATE SIGNED

10-25-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)**burial**

24B. DATE

10/27/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR**OCT 26 1950**

REGISTRAR'S SIGNATURE

William C. Lang

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.

ADDRESS

BALTO. 13, MD. Deenie J. Noel



400

50 9194

BALTIMORE CITY HEALTH DEPARTMENT

50 9194

CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. 50-2 (177122) 8998

1. NAME OF DECEASED (Type or Print) Baby Delores Cole			2. DATE OF DEATH October 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-05		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 1728 E. Madison Street		
5. SEX Female	6. COLOR OR RACE negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH October 1, 1950		9. AGE (In years last birthday) _____ II Under 1 Year Months: _____ Days: _____ II Under 24 Hours Hours: _____ Min: 19
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Mobley			14. MOTHER'S MAIDEN NAME Delores Cole		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Hospital Records		

18. 761.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO	(A) Prematurity		INTERVAL BETWEEN ONSET AND DEATH
	(B) Premature delivery		
	(C) Maternal placenta previa		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from October 1, 1950 to October 1, 1950 that I last saw the deceased alive on October 1, 1950 , and that death occurred at 8:00 Pm. , from the causes and on the date stated above.					
23A. SIGNATURE James M. Harris Jr.		23B. ADDRESS 601 N. Broadway		23C. DATE SIGNED 10-4-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Forest Park	
24D. LOCATION (City, town, or county) (State)		24E. DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1950		24F. REGISTRAR'S SIGNATURE William H. Williams	
25. FUNERAL DIRECTOR		25A. ADDRESS		25B. DATE	

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STATE OF TEXAS

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9195**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John W. Nickel

2. DATE
OF
DEATH

Oct. 24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

3436 Edmondson Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
STATE before admission)

Md.

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

3436 Edmondson Ave.

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

Married

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

May 7, 1874

9. AGE (In years
last birthday)

76

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Brewery Salesman

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Nickel

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. **153X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) **Carcinoma of the ascending colon**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

Few months

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Oct. 4, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of the ascending colon

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept. 26,** 1950 to **Oct. 24,** 1950, that I last saw the
deceased alive on **Oct. 24,** 1950, and that death occurred at **6 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE

George A. Kuiper

M. D.

23B. ADDRESS

3030 Edmondson Avenue

23C. DATE SIGNED

10/26/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 28/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral, 4300 Old Frederick Rd. Balto. Md

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Oct 26 1950

George A. Kuiper

Harry A. Buitzke, 4101 Edmondson

VS 150

0462 Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100000

STATEMENT OF DEATH

100-100000

100-100000

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9196
Registered No.

1. NAME OF DECEASED (Type or Print) Mary Agnes Walker			2. DATE OF DEATH Oct. 24/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE 307 S. Mount St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 307 S. Mount St.		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 24, 1886		9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Boland			14. MOTHER'S MAIDEN NAME Anna Stacia		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Howard E. Walker, 307 S. Mount St.		

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) Coronary Occlusion DUE TO (B) Coronary Disease DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 2 hrs 18 Mins
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, Hypertension	
	19A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **4/10**, 19**49**, to **10/24**, 19**50**, that I last saw the deceased alive on **10/28**, 19**50**, and that death occurred at **5 P.** m., from the causes and on the date stated above.

23A. SIGNATURE Samuel Katz	23B. ADDRESS 721 Madison St. Bldg.	23C. DATE SIGNED 10/25/50
--------------------------------------	--	-------------------------------------

24A. BURIAL CREMATION REMOVAL (Specify) Burial	24B. DATE Oct. 27/50	24C. NAME OF CEMETERY OR CREMATORY New Cathedral, 4300 Old Frederick Rd., Balto. Md.	24D. LOCATION (City, town, or county) (State)
--	--------------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1950	REGISTRAR'S SIGNATURE William M. ...	25. FUNERAL DIRECTOR ADDRESS 4101 Edmondson Ave
--	--	---

MARGIN RESERVED FOR BINDING
PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint, illegible handwriting and bleed-through from the reverse side of the page are visible throughout the document.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9197

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Agnes H. Crout

2. DATE
OF
DEATH

Oct. 25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2527 Hollins St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2527 Hollins St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOW, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

Dec. 2, 1863

9. AGE (In years last birthday)

86

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

H. W.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edgar Ettinger

14. MOTHER'S MAIDEN NAME

-----Bonsal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

John E. Crout (Son) 502 Glen Allen Dr.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease 10 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from August, 1948, to Oct 25, 1950, that I last saw the deceased alive on Oct 24, 1950, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Geo J. Gava

M. D.

23B. ADDRESS

1 Mallow Hill ave

23C. DATE SIGNED

Oct 26/1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 27/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950

Harry A. White

4101 Edmondson Ave.

VS 150

093 d

State of

1871

County of

City of

State of

City of

County of

State of

County of

City of

WATKINS

CRISTOFER

BOARD

MANAGER

County of

City of

State of

County of

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9198

Registered No. _____

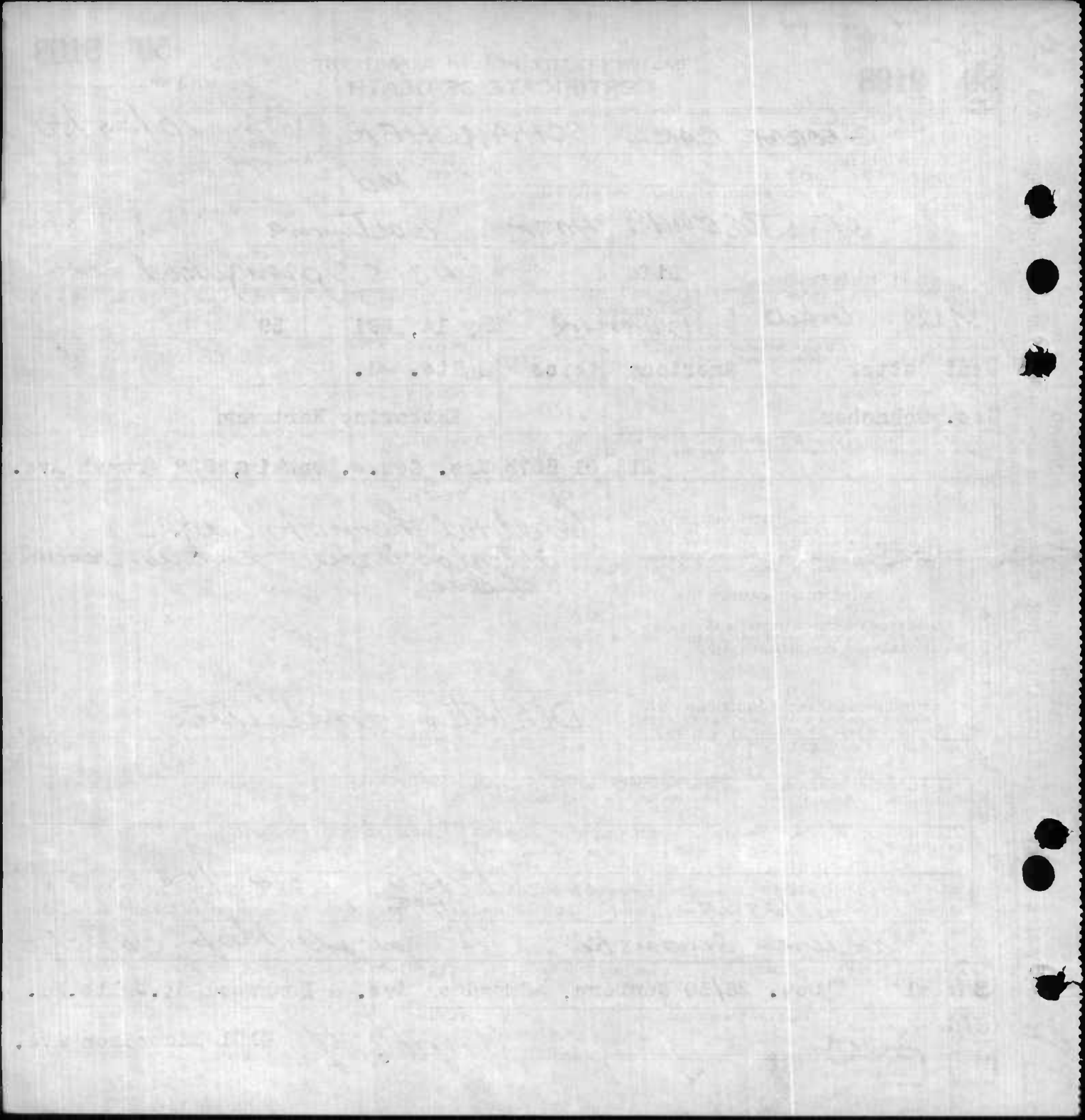
50 9198

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) GEORGE CARL SCHACHNER		2. DATE OF DEATH 10/25/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) ST. JOSEPH'S HOSP.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-01	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 4315 Springwood Ave	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 14, 1891
9. AGE (in years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10B. KIND OF BUSINESS OR INDUSTRY American Stores	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME Geo. Schacher		14. MOTHER'S MAIDEN NAME Katharine Hartmann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215 01 5573	
17. INFORMANT Mrs. Geo. W. Dawkins		ADDRESS 2928 Arunah Ave.	

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH Cerebral hemorrhage (A) DUE TO arteriosclerotic cardiovascular disease	INTERVAL BETWEEN ONSET AND DEATH _____
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO _____	_____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Diabetes mellitus	_____

19A. DATE OF OPERATION 10/25/50		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 10/7/50 , to 10/25/50 , that I last saw the deceased alive on 10/25/50 , and that death occurred at 7:05 P.M. , from the causes and on the date stated above.					
23A. SIGNATURE Maddens Swinski		23B. ADDRESS St. Joseph's Hosp		23C. DATE SIGNED 10/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Oct. 28/50	24C. NAME OF CEMETERY OR CREMATORY Western, Edmondson Ave. & Longwood St.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1950	REGISTRAR'S SIGNATURE Harry A. Lutzke	25. FUNERAL DIRECTOR Harry A. Lutzke		ADDRESS 4101 Edmondson Ave.	



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9199**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)**Crispino DeMarco**2. DATE
OF
DEATH**Oct. 25/50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BaltimoreB. FULL NAME OF
HOSPITAL OR
INSTITUTION**407 Kingston Rd**

c. Length of stay in Baltimore

LifeYrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

407 Kingston Rd

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

Single

8. DATE OF BIRTH

July 31, 1898

9. AGE (In years last birthday)

52

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

NEVER WORKED

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Salvatore DeMarco

14. MOTHER'S MAIDEN NAME

Maria-----15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

P. Charles DeMarco, 507 Stamford Rd.18. **491X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)(A) **Scholar Pneumonia.**
DUE TOINTERVAL BETWEEN
ONSET AND DEATH**3 days**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct 22**, 19**50**, to **Oct 25**, 19**50**, that I last saw the deceased alive on **Oct 25**, 19**50**, and that death occurred at **8 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 28/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral, 4300 Old Frederick Rd. Balto. Md

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950**4101 Edmondson Ave.**

1000

1000

1000

1000

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50 9200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9200

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

LUGENE HEGGINS

2. DATE
OF
DEATH

October 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONUS Marine Hospital
Wyman Pk. Drive & 31st St.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1909 Harlem Avenue

c. Length of stay in Baltimore

151 days

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

col

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

10/31/98

9. AGE (In years
last birthday)

51

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

NC

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Heggins

14. MOTHER'S MAIDEN NAME

Loutora Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT ADDRESS
Records- US Marine Hospital, Balto, Md.

18. 011X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Tuberculosis, abdominal

DUE TO

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from May 26, 1950, to Oct. 24, 1950, that I last saw the
deceased alive on Oct. 24, 1950 and that death occurred at 6:33P m., from the causes and on the date stated above.

23A. SIGNATURE John L. Wilson

23B. ADDRESS

23C. DATE SIGNED

John L. Wilson, Medical Director M. D.

US Marine Hospital, Balto, Md.

10/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 26 1950

+ Huntington Wilson, M.D.

Mrs. Kate P. Williams

Schroeder

VS 150

82010

0150

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

8800

30

8800

30

CERTIFICATE OF DEATH

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>		<p>7. Time of death</p>		<p>8. Cause of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Signature of witness</p>	
<p>13. Signature of funeral director</p>		<p>14. Signature of undertaker</p>		<p>15. Signature of cemetery</p>		<p>16. Signature of burial place</p>	
<p>17. Signature of burial place</p>		<p>18. Signature of burial place</p>		<p>19. Signature of burial place</p>		<p>20. Signature of burial place</p>	
<p>21. Signature of burial place</p>		<p>22. Signature of burial place</p>		<p>23. Signature of burial place</p>		<p>24. Signature of burial place</p>	
<p>25. Signature of burial place</p>		<p>26. Signature of burial place</p>		<p>27. Signature of burial place</p>		<p>28. Signature of burial place</p>	
<p>29. Signature of burial place</p>		<p>30. Signature of burial place</p>		<p>31. Signature of burial place</p>		<p>32. Signature of burial place</p>	
<p>33. Signature of burial place</p>		<p>34. Signature of burial place</p>		<p>35. Signature of burial place</p>		<p>36. Signature of burial place</p>	
<p>37. Signature of burial place</p>		<p>38. Signature of burial place</p>		<p>39. Signature of burial place</p>		<p>40. Signature of burial place</p>	
<p>41. Signature of burial place</p>		<p>42. Signature of burial place</p>		<p>43. Signature of burial place</p>		<p>44. Signature of burial place</p>	
<p>45. Signature of burial place</p>		<p>46. Signature of burial place</p>		<p>47. Signature of burial place</p>		<p>48. Signature of burial place</p>	
<p>49. Signature of burial place</p>		<p>50. Signature of burial place</p>		<p>51. Signature of burial place</p>		<p>52. Signature of burial place</p>	
<p>53. Signature of burial place</p>		<p>54. Signature of burial place</p>		<p>55. Signature of burial place</p>		<p>56. Signature of burial place</p>	
<p>57. Signature of burial place</p>		<p>58. Signature of burial place</p>		<p>59. Signature of burial place</p>		<p>60. Signature of burial place</p>	
<p>61. Signature of burial place</p>		<p>62. Signature of burial place</p>		<p>63. Signature of burial place</p>		<p>64. Signature of burial place</p>	
<p>65. Signature of burial place</p>		<p>66. Signature of burial place</p>		<p>67. Signature of burial place</p>		<p>68. Signature of burial place</p>	
<p>69. Signature of burial place</p>		<p>70. Signature of burial place</p>		<p>71. Signature of burial place</p>		<p>72. Signature of burial place</p>	
<p>73. Signature of burial place</p>		<p>74. Signature of burial place</p>		<p>75. Signature of burial place</p>		<p>76. Signature of burial place</p>	
<p>77. Signature of burial place</p>		<p>78. Signature of burial place</p>		<p>79. Signature of burial place</p>		<p>80. Signature of burial place</p>	
<p>81. Signature of burial place</p>		<p>82. Signature of burial place</p>		<p>83. Signature of burial place</p>		<p>84. Signature of burial place</p>	
<p>85. Signature of burial place</p>		<p>86. Signature of burial place</p>		<p>87. Signature of burial place</p>		<p>88. Signature of burial place</p>	
<p>89. Signature of burial place</p>		<p>90. Signature of burial place</p>		<p>91. Signature of burial place</p>		<p>92. Signature of burial place</p>	
<p>93. Signature of burial place</p>		<p>94. Signature of burial place</p>		<p>95. Signature of burial place</p>		<p>96. Signature of burial place</p>	
<p>97. Signature of burial place</p>		<p>98. Signature of burial place</p>		<p>99. Signature of burial place</p>		<p>100. Signature of burial place</p>	

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9201
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

(Margaret E. Wollschlager)

2. DATE
OF
DEATH

10/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

7. STREET ADDRESS (If rural, give location)

2109 Greenmount Avenue

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

May 25th., 1875

9. AGE (In years last birthday)

75

If Under 1 Year Months: Days

4 29

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Schleigh

14. MOTHER'S MAIDEN NAME

Catherine Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mr. Leroy C. Wollschlager-2109 Greenmount Ave.

ADDRESS

18. 4-20-1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Antecedent Cause

DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER ☐

10/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-28-50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county) (State)

Taylor Ave. Balto: Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

George J. Ruth, Inc. - 1735 Harford Avenue

1000

1000



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 9202

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

NICK PAPPAS

2. DATE
OF
DEATHOct. 25, 1950
10:45 AM

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md. Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Mary Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 2-03

c. Length of stay in Baltimore

20

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1704 Lancaster Street

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8-6-1898

9. AGE (In years last birthday)

52

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tavern Owner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Pappas

14. MOTHER'S MAIDEN NAME

Ester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mary Binick

ADDRESS

Same

18. 163X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

CAUSE OF DEATH

Cardiac failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Carcinoma, lung, left

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

April 1950

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1950, to Oct. 25, 1950, that I last saw the deceased alive on Oct. 25, 1950, and that death occurred at 10:45 PM., from the causes and on the date stated above.

23A. SIGNATURE

[Signature]

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

DATE RECEIVED BY LOCAL REGISTRAR

24B. DATE

Oct 28/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Rosary

24D. LOCATION (City, town, or county)

Baltimore

(State)

REGISTRAR'S SIGNATURE

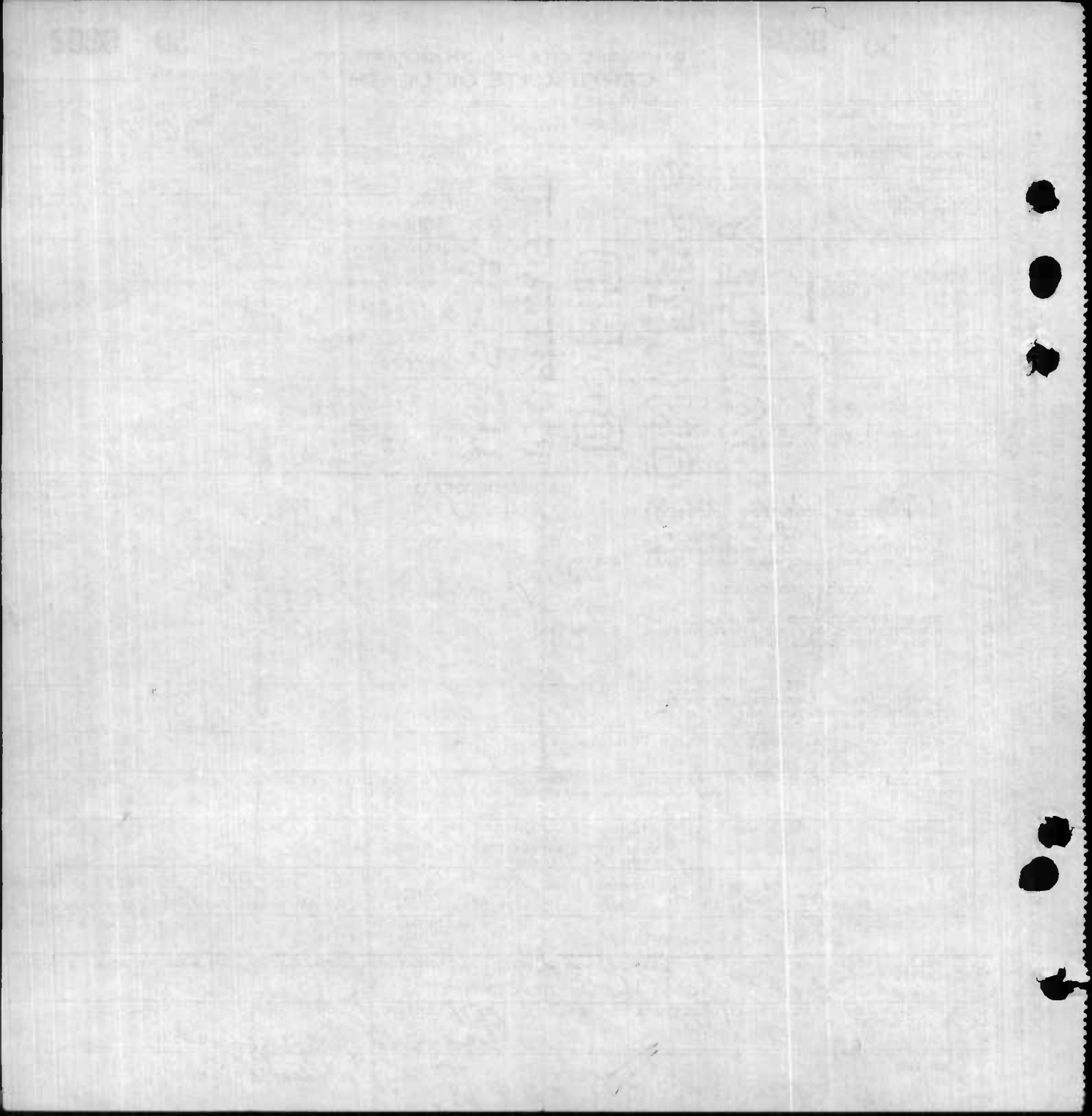
FUNERAL DIRECTOR

ADDRESS

Fred H. Orazowski

VS 150

Dr. D. KOLACSKOVSKY 2906 M 1900 Federal Ter. 047d



50 9203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9203
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JENNIE

SMOTRITSKY

2. DATE
OF
DEATH

October 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 10-62D. STREET ADDRESS (If rural, give location)
1029 Wilnot Court

c. Length of stay in Baltimore

50 yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

May-1890

9. AGE (In years
last birthday)

60

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Coat Finisher

10B. KIND OF BUSINESS OR INDUSTRY

Tailor Shop (M)

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?
USA.

13. FATHER'S NAME

Hymen Smotritsky

14. MOTHER'S MAIDEN NAME

Beala Venze

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Joseph E. Sohmer-3000 Cold Spring Lane

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular

disease with coronary sclerosis and occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William V. Smith*23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct. 26, 1950

24A. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

10-27-50

24C. NAME OF CEMETERY OR CREMATORY

Ansh Sfard Cong. German Hill Rd.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Sol. Levinson & Bros. - 1124-26 W. North Avenue

VS 151

69046

0932

Avenue

MARGIN RESERVED FOR BINDING
PLEASE WRITE ONLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1958

06

FACSIMILE COPY RECORDS
CERTIFICATE OF DEATH

1958

06



M-556
MARGIN RESERVED FOR BINDING
PLEASE WRITE ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9204

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) CHARLES GREGORY MONMONIER		2. DATE OF DEATH 10/25/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) ST. JOSEPH'S HOSP		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Upper Falls (RURAL)	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 5300	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH Dec. 25-1869
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9B. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) Months Days 79 10
10A. FATHER'S NAME Chas. H. Monmonier		10B. CITIZEN OF WHAT COUNTRY? md.	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. SOCIAL SECURITY NO.	
13. MOTHER'S MAIDEN NAME Elizabeth Armstrong		14. INFORMANT ADDRESS Mrs. Monmonier Bradshaw Ind	

18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Congestive heart failure arteriosclerotic heart disease	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 10/25/50 , to 10/25/50 , that I last saw the deceased alive on 10/25/50 , and that death occurred at 8:52 m., from the causes and on the date stated above.				
23A. SIGNATURE Maddens Swinski		23B. ADDRESS St. Joseph's Hosp.		23C. DATE SIGNED 10/25/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Oct 28-50	24C. NAME OF CEMETERY OR CREMATORY St. Stephens Cem	24D. LOCATION (City, town, or county) (State) Bradshaw-Balts & Ind	
DATE RECEIVED BY LOCAL REGISTRAR Oct 27 1950		25. FUNERAL DIRECTOR ADDRESS G. E. Arthur Fork Ind.		

CLLP

10000000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9205

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles E. Lloyd

2. DATE OF DEATH
10-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 12-02D. STREET ADDRESS (If rural, give location)
3407 Barclay St #18

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days5. SEX
Male
Colored6. COLOR OR RACE
Negro7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married8. DATE OF BIRTH
11-10-18759. AGE (In years last birthday)
7410. Under 1 Year
Months Days
11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
valet10B. KIND OF BUSINESS OR INDUSTRY
PRIVATE11. BIRTHPLACE (State or foreign country)
Maryland12. CITIZEN OF WHAT COUNTRY?
USA.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT
Wife Cora V. LloydADDRESS
as above

18. 151X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal bronchopneumonia

unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Stomach with metastases - bone

unknown

DUE TO

(C) unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/9, 1950 to 10/24, 1950 that I last saw the deceased alive on 10/24, 1950 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louisa Candler

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

10-24-50

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

OCT 28 1950

24C. NAME OF CEMETERY OR CREMATORY

Hilatus Memorial Park

24D. LOCATION (City, town, or county)

Baltimore Co., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 27 1950

REGISTRAR'S SIGNATURE

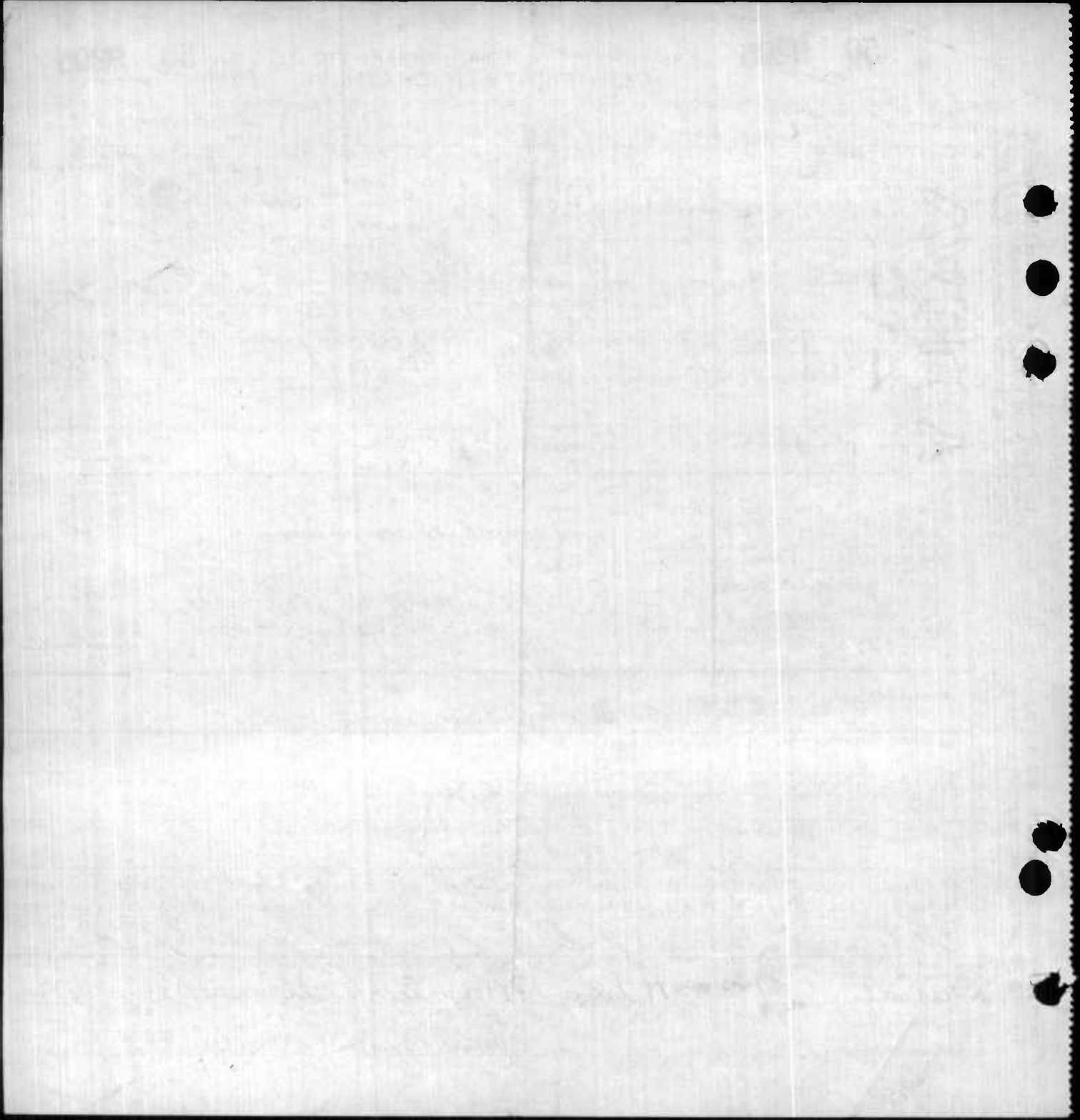
Marguerite Louisa Candler

25. FUNERAL DIRECTOR

Interment Co. Hemlock

ADDRESS

578 W. Biddle St.



50 9206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9206
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JACOB RUIE

2. DATE
OF
DEATH

10-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTIONMt. Sinai Home
4613 Park Heights Ave
Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3016 Walbrook Ave.

c. Length of stay in Baltimore

Yrs. 45
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (in years
last birth day)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

67

10A. USUAL OCCUPATION (Give kind of
work during most of working life, even if retired)

Dresser

10B. KIND OF BUSINESS OR
INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph

14. MOTHER'S MAIDEN NAME

Elena

15. HAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Berrie Franklin - 2534 Quantico

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute Corbise dilatation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Coronary Sclerosis

DUE TO

(C) General arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 10/23, 1950, to 10/25, 1950, that I last saw the
deceased alive on 10/25, 1950, and that death occurred at 1 PM, from the causes and on the date stated above.

23A. SIGNATURE

A. H. Hornstein

23B. ADDRESS

204 E. Biddle St

23C. DATE SIGNED

10/26/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

10-27-50

24C. NAME OF CEMETERY OR CREMATORY

Mt Carmel

24D. LOCATION (City, town, or county)

Baltimore, Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. L. Williams

25. FUNERAL DIRECTOR

Jaeger

ADDRESS

2100 E. Howard St

OCT 27 1950

VS 150

690 4G

094a

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Horanstein
not 8 Biddle St

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) *Herbert L Armiger*

2. DATE
OF
DEATH *Oct 24 - 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *3312 Elm Ave*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Md*

B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION _____

C. CITY OR TOWN _____

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) *3312 Elm Ave*

C. Length of stay in Baltimore *Life*

Yrs.
Mos.
Days

5. SEX *Male*

6. COLOR OR RACE *White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Married*

8. DATE OF BIRTH *Oct 12 - 1896*

9. AGE (In years last birthday) *34*

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Machine operator*

10B. KIND OF BUSINESS OR INDUSTRY *Machine Shop*

11. BIRTHPLACE (State or foreign country) *Md.*

12. CITIZEN OF WHAT COUNTRY? *USA*

13. FATHER'S NAME *Charles Armiger*

14. MOTHER'S MAIDEN NAME *Lillian Rain*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. *215-01-584*

17. INFORMANT *Bora Armiger*

ADDRESS *3312 Elm Ave*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Disease of the coronary arteries -*

DUE TO

Immediate

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Unknown*

DUE TO

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *about Jan*, 19*48* to *24 Oct*, 19*50*, that I last saw the deceased alive on *about Jan*, 19*50*, and that death occurred at *9:00 P.* m., from the causes and on the date stated above.

23A. SIGNATURE *Blair B. W. [Signature]*

23B. ADDRESS *20204 Charles St*

23C. DATE SIGNED *26 Oct 50 -*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*

24B. DATE *Oct 28 - 50*

24C. NAME OF CEMETERY OR CREMATORY *Woodlawn*

24D. LOCATION (City, town, or county) (State) *Baltimore Md*

DATE RECEIVED BY LOCAL REGISTRAR *OCT 27 1950*

REGISTRAR'S SIGNATURE *William [Signature]*

25. FUNERAL DIRECTOR *Frank A. Seitz*

ADDRESS *814 1/2 36th St.*

VS 150

6903L

094a

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

YANLEY

1910

1910

1910

1910



17-522
50 9208BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9208
Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOACHIM KANIGOWSKI

2. DATE

OF

DEATH October 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 3-02D. STREET ADDRESS (If rural, give location)
1030 E. Lombard Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

9. AGE (In years
last birthday)
63If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Crown Cork & Seal

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

L

14. MOTHER'S MAIDEN NAME

L

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-20-0964

17. INFORMANT

ADDRESS

Martin Naparstek 5018 Lakewood Ave.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

William V. Sobush

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

October 26, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Oct 28-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Rosary

24D. LOCATION (City, town, or county)

Balto. Co.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

ADDRESS

Wm. S. Fialkowski 2007 Eastern Ave

VS 151

97032

093d

✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8052

52

UNITED STATES DEPARTMENT OF THE INTERIOR

8052

52

OFFICE OF THE SECRETARY OF THE INTERIOR



MARGIN RESERVED FOR BINDING
PLEASE WRITE CORRECTLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 11-17-50

50 9210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9210

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EMMA E. WESTENDORF			2. DATE OF DEATH Oct. 25, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 5411 Grindon Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 106			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-08		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 2031 Robb St.		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 18, 1879	9. AGE (In years last birthday) 71	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Carey S. Wright			14. MOTHER'S MAIDEN NAME Mary E. Kirby		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. no	17. INFORMANT ADDRESS MRS. F. D. Macneal 5411 Grindon Ave.		

18. 153X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma, generalized

INTERVAL BETWEEN ONSET AND DEATH 1 month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Adenocarcinoma of caecum

9 months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

(C)

19A. DATE OF OPERATION 12 Feb 50 and 1 Mar 50		19B. MAJOR FINDINGS OF OPERATION Adenocarcinoma of caecum		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11 Feb 1950, to 24 Oct 1950, that I last saw the deceased alive on 24 Oct 1950, and that death occurred at 6:40 A. M., from the causes and on the date stated above.					
23A. SIGNATURE John N. Barnaby		23B. ADDRESS 1531 E North Ave M. D.		23C. DATE SIGNED 26 Oct 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/28/50		24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 27 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR ADDRESS Wm. J. Jackson - Sons Inc. Balto Md	

0150

0150

00

REPRODUCTION OF



50 9211

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9211

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ruth McConnell

2. DATE
OF
DEATH

10-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Mary Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1008 Mosher St

c. Length of stay in Baltimore

17yrs

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

4-14-1916

9. AGE (In years,
last birthday)

34

If Under 1 Year
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR
INDUSTRY

Dressmaking (M)

11. BIRTHPLACE (State or foreign country)

Shelton, S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Will Woodard

14. MOTHER'S MAIDEN NAME

Ada Edrington

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

218-22-5120

17. INFORMANT

ADDRESS

Johnnie McConnell-1008 Mosher St

18. 451X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Dissecting aneurysm
of ascending aorta

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

9 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Hypertension

DUE TO

6 Months

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-18, 1950, to 10-25, 1950, that I last saw the
deceased alive on 10-25, 1950, and that death occurred at 5:50 P.M., from the causes and on the date stated above.

23A. SIGNATURE

R. Fravel

23B. ADDRESS

Mary Hospital

23C. DATE SIGNED

10-26-50

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/29/50

24C. NAME OF CEMETERY OR CREMATORY

McConnell Cemetery

24D. LOCATION (City, town, or county)

Shelton, S.C.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Holliday

25. FUNERAL DIRECTOR

Chas. H. H. H.

ADDRESS

512 N. Carrollton Ave

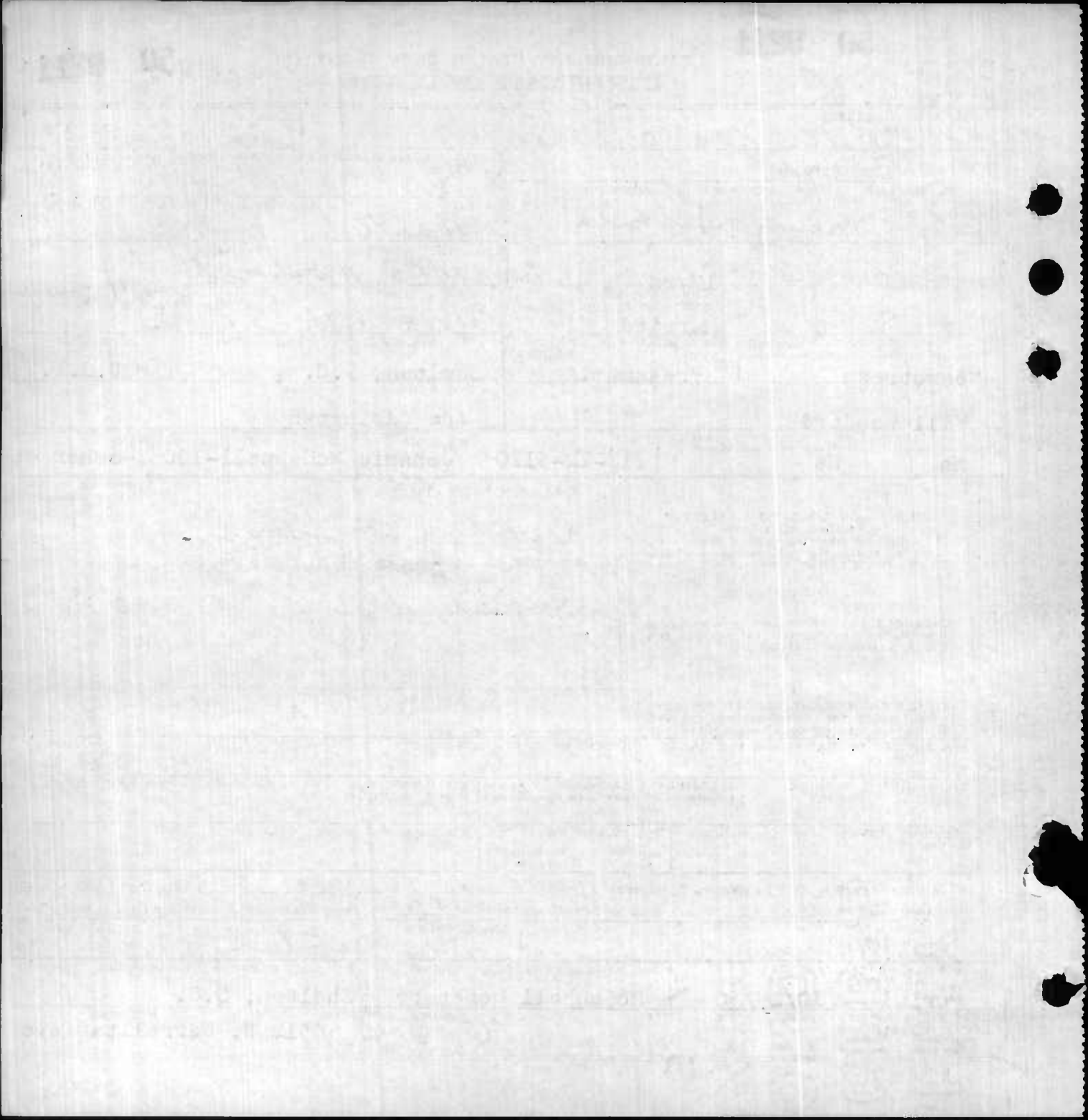
VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



50 9212

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9212

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK P. CASE

2. DATE
OF
DEATH

10/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

University

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

19-04

c. Length of stay in Baltimore

4.5 yrs

Yrs.
Mos.
Days

6. STREET ADDRESS (If rural, give location)

409 S. Vincent St

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 8, 1873

9. AGE (In years
last birthday)

77

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR
INDUSTRY

B. & O.

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Case

14. MOTHER'S MAIDEN NAME

Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Elizabeth Case, 409 S. Vincent St

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerotic Cardiovascular dis.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Uremia

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 10/25, 1950, to 10/26, 1950 that I last saw the
deceased alive on 10/26, 1950, and that death occurred at 8:48 m., from the causes and on the date stated above.

23A. SIGNATURE

Edwin M. Hubbard

M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

10/26/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 28/50

24C. NAME OF CEMETERY OR CREMATORY

London Pk. 380 Frederick Ave. Bkts. Ind.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

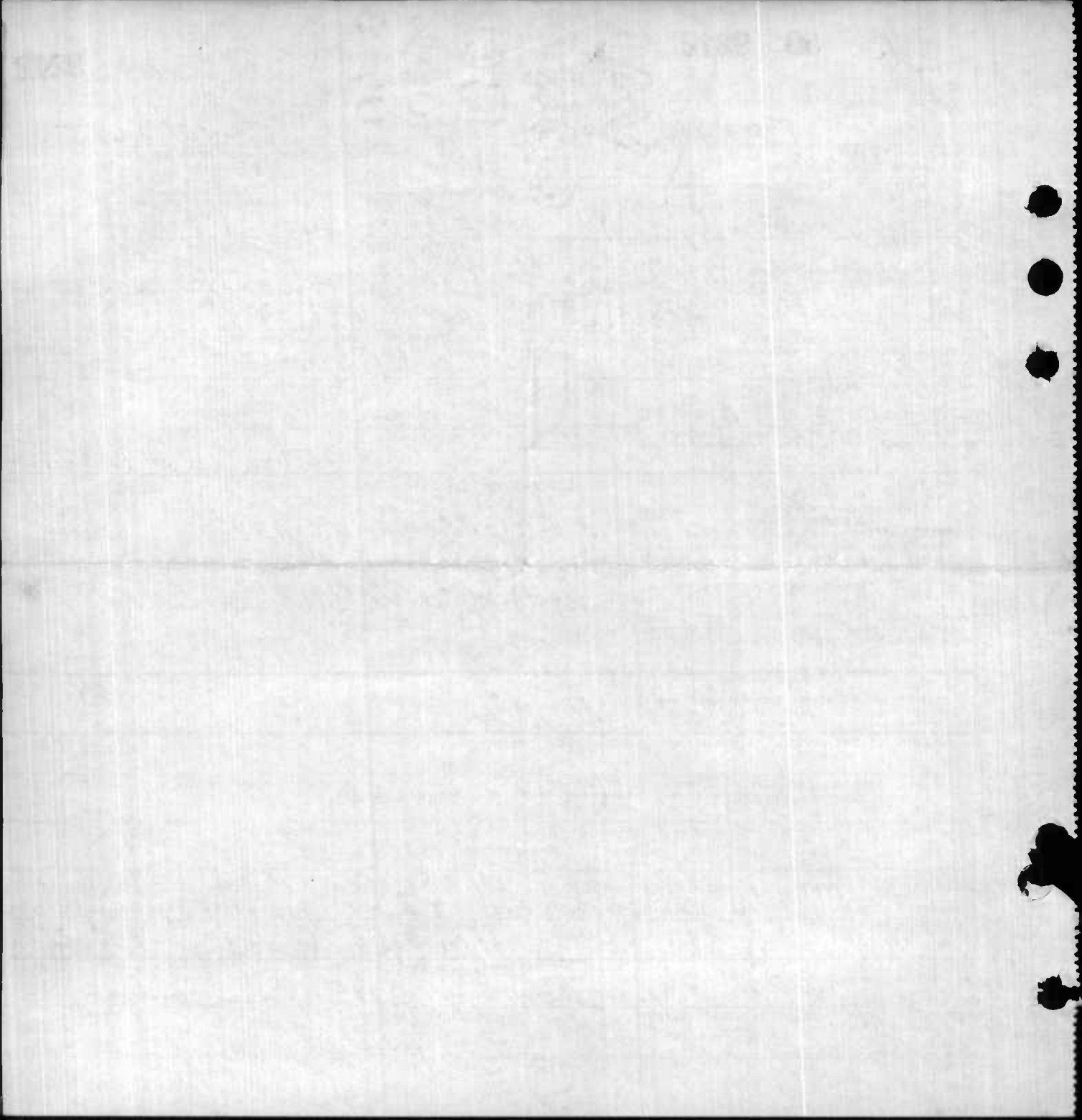
25. FUNERAL DIRECTOR

ADDRESS

OCT 27 1950

Washington Bldg.

Harold F. Smith, 4101 Edmondson



50 9213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9213

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LAURA R. TAYMAN

2. DATE
OF
DEATH

10-75-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTO. CITY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

MERCY HOSP INC.
BALTIMORE, MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE ZONE X3 19-64

c. Length of stay in Baltimore

LIFE

D. STREET ADDRESS (If rural, give location)

119 SOUTH FULTON AVE

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

DEC. 1866

9. AGE (In years last birthday)

89

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

EDWARD DOYLE

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL SECURITY NO.

-NONE

17. INFORMANT

PATIENT

ADDRESS

SAME

18.

153X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA (ADENO-CARCINOMA) CECUM.

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

APPROX 1 YR.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) INTESTINAL OBSTRUCTION

DUE TO

2 WKS.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

19A. DATE OF OPERATION

10-4-50

19B. MAJOR FINDINGS OF OPERATION

CA. OF CECUM - OBSTRUCTING

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 22, 1950, to Oct 25, 1950, that I last saw the deceased alive on Oct 25, 1950, and that death occurred at 10:05 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Kenneth D. Smelser M.D.

23B. ADDRESS

Mercy Hospital Inc.

23C. DATE SIGNED

10-75-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 30/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral 4306 Old Fredk. Rd. Balto. Md

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Harry F. Lutzke, 4108 Edmondson

ADDRESS

30 0010

STATE OF TEXAS
COUNTY OF DALLAS

30 0010



M-600

50 9214

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9214

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Ray Moore

2. DATE
OF
DEATH

10-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

20-08

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

305 Collins Ave South

c. Length of stay in Baltimore

50

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

3-9-1891

9. AGE (In years
last birthday)

59

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Newspaper Supervisor

10B. KIND OF BUSINESS OR
CIRCULATION

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Albert Moore dead

14. MOTHER'S MAIDEN NAME

Margaret J. Riston dead

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Katherine Moore 305 S Collins Ave

18.

331X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 24, 1950, to Oct. 26, 1950, that I last saw the deceased alive on Oct. 26, 1950, and that death occurred at 8:17 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

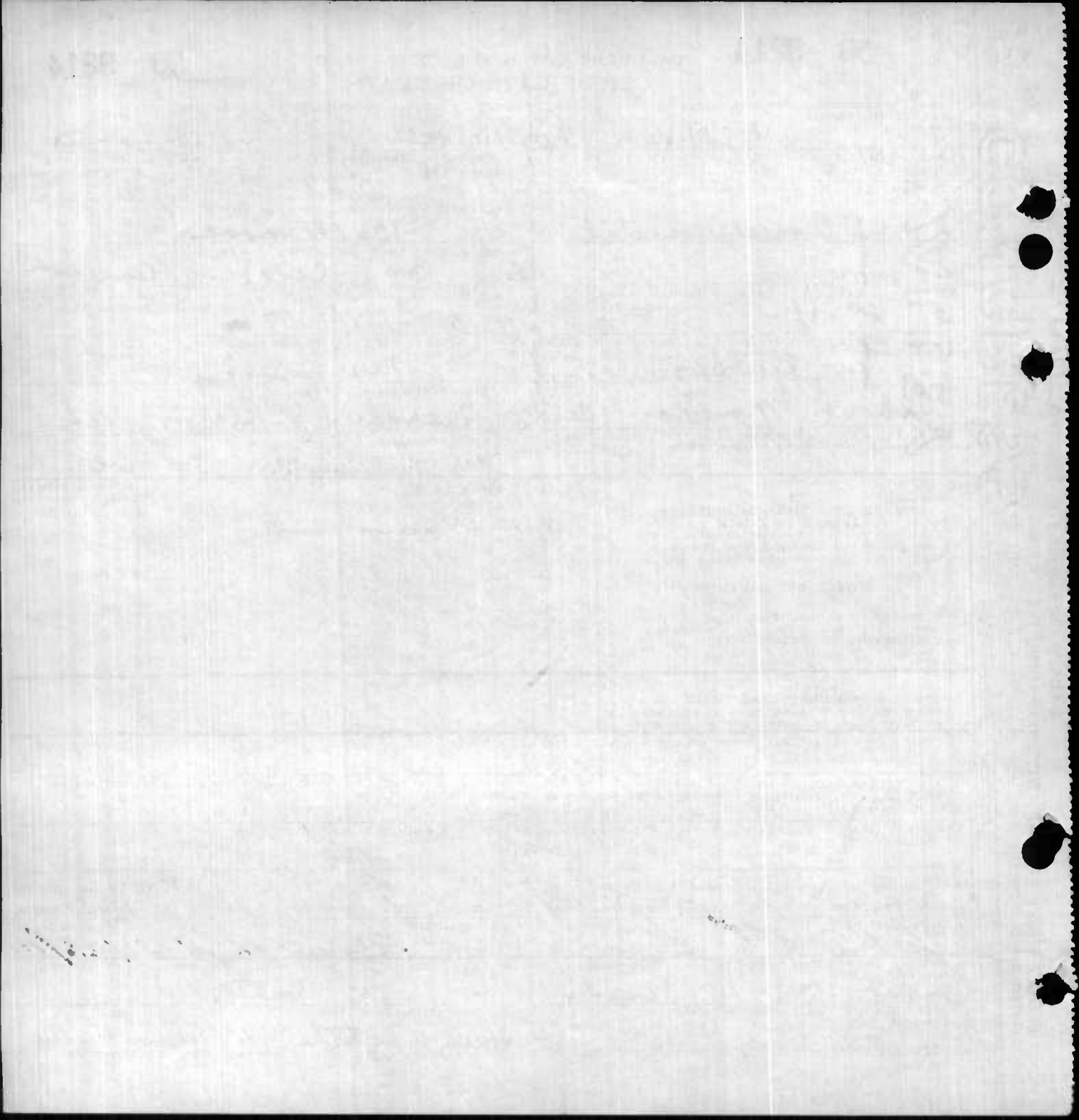
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9215

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Daniel H. Ledley2. DATE
OF
DEATHOct. 26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Md. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

779 W. Cross St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore2-1-01

D. STREET ADDRESS (If rural, give location)

779 W. Cross St.

c. Length of stay in Baltimore

LifeYrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 30, 1888

9. AGE (In years last birthday)

62

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR OCCUPATION

C. & P. Telephone Co.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Ledley

14. MOTHER'S MAIDEN NAME

Mary Nance

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Virginia Alt, 210 S. Payson St.18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Myocardial Infarction
DUE TO2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Artery Disease
DUE TO5 years(C) Arteriosclerosis
DUE TO3

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from 10-25, 1950, to 10-26, 1950, that I last saw the deceased alive on 10-26, 1950, and that death occurred at 11:54 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John P. Unack, Jr.

M. D.

23B. ADDRESS

1227 Washington Blvd

23C. DATE SIGNED

10-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 30/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park, 3801 Frederick Ave. Balto. Md.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

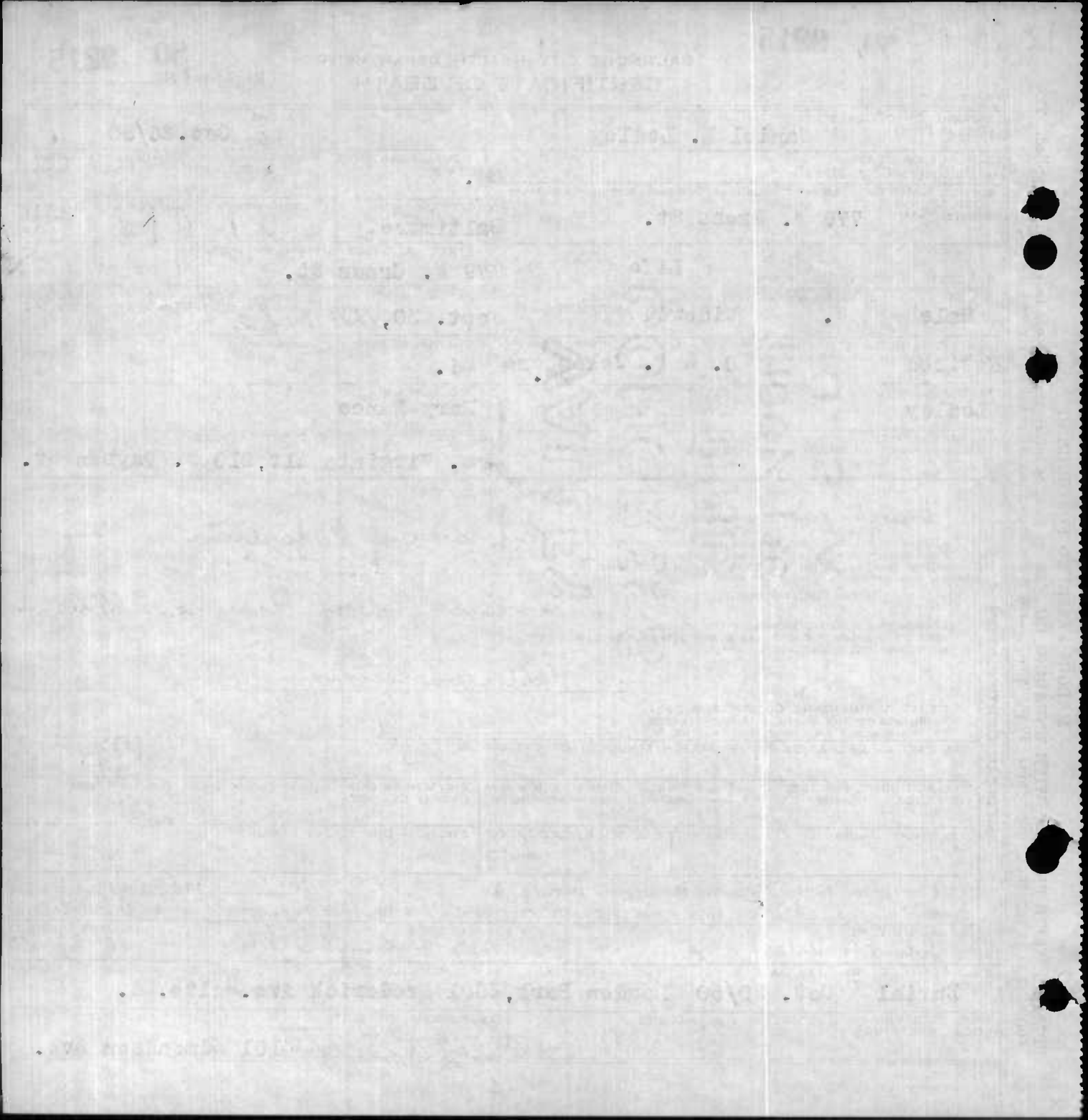
ADDRESS

OCT 27 1950Walter J. Unack, Jr.Walter J. Unack, Jr.4101 Edmondson Ave.

VS 150

5A

094a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9216**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST BROWN

2. DATE
OF
DEATH

October 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Maryland**

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
1600 W. Franklin Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12/25/85

9. AGE (In years last birthday)

64

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Freight handler

10B. KIND OF BUSINESS OR INDUSTRY

BRO. R.R. Co.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

705-09-6607

17. INFORMANT

ADDRESS

Lillie Mae Brown 308 W. Hoffman St

18. **443X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Hypertensive cardiovascular disease with myocardial insufficiency**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R.S. Fisher

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Oct. 25, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-30-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 27 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

THE CHARLES R. LAW MORTUARY

VS 151

970 50 093 d

802-04 MADISON AVENUE

BALTIMORE 1, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3132

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3132/02

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9217

Registered No. _____

W-452
50 9217
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Maggie Williams			2. DATE OF DEATH October 26, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION 921 Carrolton Ave.			C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore		
c. Length of stay in Baltimore 6 Years			D. STREET ADDRESS (If rural, give location) 921 Carrolton Ave. N.		
5. SEX FE	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept. 15, 1866	9. AGE (In years last birthday) 84	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Elijah Pinkett			14. MOTHER'S MAIDEN NAME Maria Pinkett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Howard Williams		

18. 174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Uterus			CAUSE OF DEATH Carcinoma of Uterus			INTERVAL BETWEEN ONSET AND DEATH ?		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO					
19A. DATE OF OPERATION 9		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from Jan. 1949 , to Oct 26, 1950 , that I last saw the deceased alive on Oct 26, 1950 , and that death occurred at 7 1/2 m. , from the causes and on the date stated above.								
23A. SIGNATURE Stanford P. Munsende				23B. ADDRESS 2509 2nd Hill		23C. DATE SIGNED Oct. 27		
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 10/28/50		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Balto Co., Md.		
DATE RECEIVED BY LOCAL REGISTRAR Oct 27 1950		REGISTRAR'S SIGNATURE Stanford P. Munsende		25. FUNERAL DIRECTOR Charles E. Law		ADDRESS 802 Madison Ave.		

VS 150

0486

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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18/02/74

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K-523
50 9218BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9218

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Knight

2. DATE
OF
DEATH

Oct 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTO. MD

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1409 LOWMAN St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

1409 LOWMAN ST.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1409 LOWMAN ST.

5. SEX

M

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

JAN 1890

9. AGE (in years last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CHECKER SALVATION ARMY

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE MARYLAND AMERICA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

GEORGE HENRY KNIGHT

14. MOTHER'S MAIDEN NAME

SARA HAYES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

705-09-0235

17. INFORMANT

ADDRESS

MARIE ABBOTT 1409 LOWMAN

18. 420.0
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Acute Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

5 min.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Anterior Septal Heart disease
decompensation
Generalized arteriosclerosis (12 mo)
Left ventricular hypertrophy - congestive
thrombosis

5-8 yr.

5-8 yr.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

1 hr

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 1950, to Oct 24, 1950, that I last saw the deceased alive on Oct 21, 1950, and that death occurred at 12:00 M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

642 Wash St.

23C. DATE SIGNED

10-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

10/28/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Carmel C.

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

Chas J. Bell - 1501 E Fort Ave

ADDRESS

VS 150

390 8W

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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96

3129

97



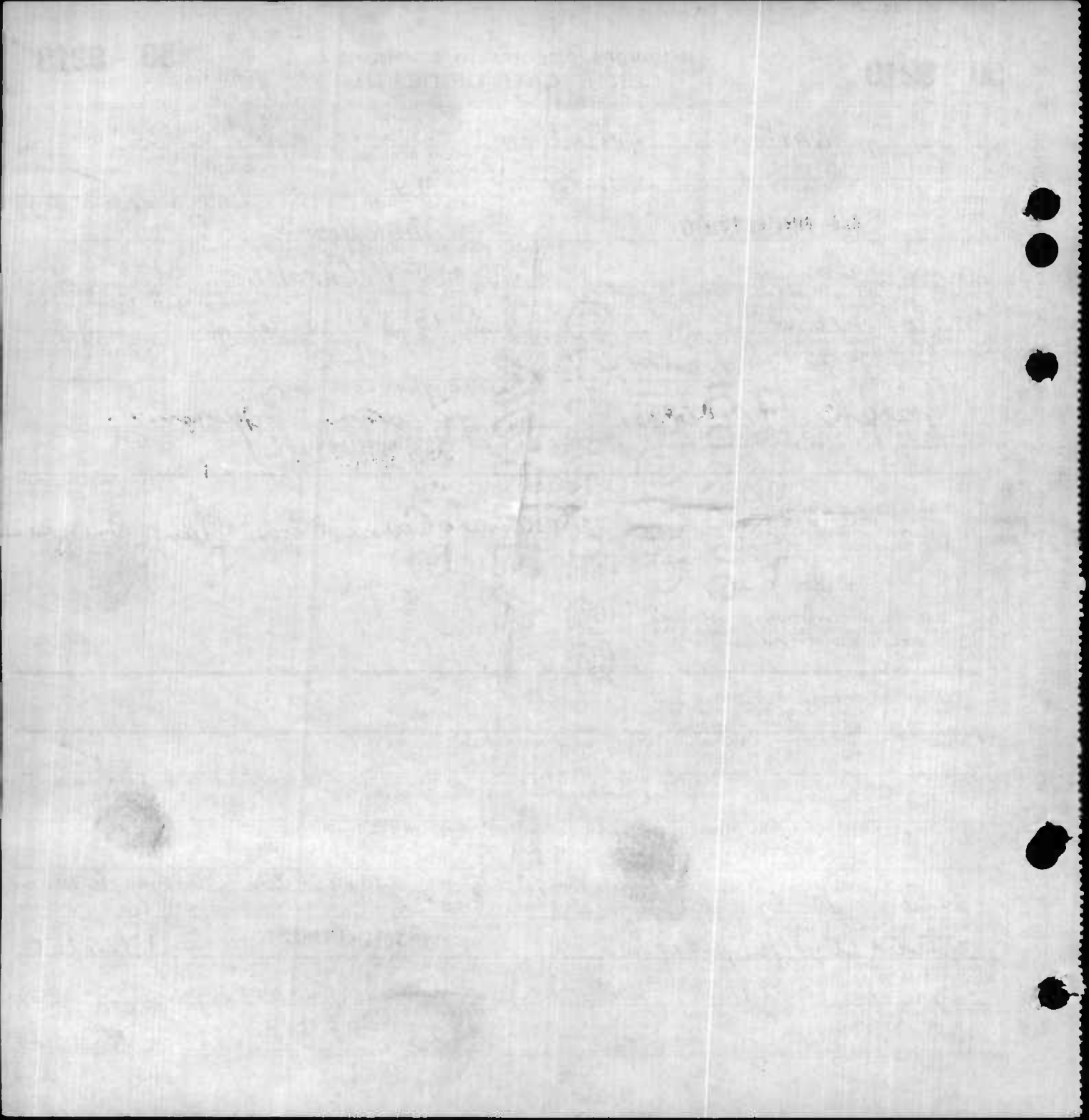
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9219

BIRTH NO. 50 9219		1. NAME OF DECEASED (Type or Print) <i>Walter Dalton</i>		2. DATE OF DEATH OCT 24 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>6-05</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>45 N. Caroline St.</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>8-13-88</i>	9. AGE (in years last birthday) <i>62</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Flower Yard</i>		11. BIRTHPLACE (State or foreign country) <i>U.C.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Joseph Dalton</i>		14. MOTHER'S MAIDEN NAME <i>Lusan Gwynn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS	
18. <i>162x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>I</i> CAUSE OF DEATH <i>Primary Carcinoma of lung One year</i>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10-17-</i> 1950, to <i>10-24-</i> 1950, that I last saw the deceased alive on <i>10-24-</i> 1950, and that death occurred at <i>3:45 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Arthur G. McFadden</i> M. D.		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>10/27/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/27/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Int. Calvary Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn Md</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 27 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wm. H. Wilson</i>	
24G. FUNERAL DIRECTOR <i>Wm. H. Wilson</i>		24H. ADDRESS <i>1000 Brandt</i>		24I. VS 150	

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NO 1220

FALLBROOK CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

NO 1220
FALLBROOK, ILL.

1901

CAUSE OF DEATH

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9221**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)**EDGAR GARRETT**2. DATE
OF
DEATH**10/25/50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION**Lutheron Hospital of Md.**

C. CITY OR TOWN

(If outside corporate limits, write town, and give township)

Balto

D. STREET ADDRESS (If rural, give location)

3811 Walnut Ave Crofton

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)**M**

8. DATE OF BIRTH

11/2/1885

9. AGE (In years

last birthday)

64

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)**Laborer**10B. KIND OF BUSINESS OR
INDUSTRY**Penna R.R.**

11. BIRTHPLACE (State or foreign country)

Balto Md12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wm Harper Garrett

14. MOTHER'S MAIDEN NAME

Catherine Knight15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)**No**

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.**77-07-7146**

17. INFORMANT

ADDRESS

Agnes Garrett 3811 Walnut Ave18. **420.1**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) **Cerebral Thrombosis**

DUE TO

2 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) **Arteriosclerosis (generalized)**

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C) **Hypertensive crd & coronary
arteriosclerosis + ingestion cold**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 24**, 19**50** to **Oct. 25**, 19**50**; that I last saw the
deceased alive on **Oct. 25**, 19**50**, and that death occurred at **11⁵⁵ P.m.**, from the causes and on the date stated above.

23A. SIGNATURE

M. E. Edwards

M. D.

23B. ADDRESS

Lutheron Hosp. of Md.

23C. DATE SIGNED

10/25/5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)**Burial**

24B. DATE

10/28/50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Balto, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR**OCT 27 1950**

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm Cook Inc 1217 St. Paul St

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S-534

50 9222

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9222

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis Sendldorfer			2. DATE OF DEATH October 27, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 2614 Harford Road			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 2614 Harford Road		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 8, 1892		9. AGE (in years; last birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Louis Sendldorfer			14. MOTHER'S MAIDEN NAME Katherine Heckel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Mrs. Theresa Sendldorfer, 2614 Harford Rd.		

18. 592X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) VIOLATION (A) DUE TO		CAUSE OF DEATH Chronic Glomerulonephritis (B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years 10 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO Hypertension, Chronic Venous Disease			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 19, 1950 , to October 27, 1950 , that I last saw the deceased alive on October 19, 1950 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.					
23A. SIGNATURE Dr. F. J. Poleski		23B. ADDRESS 1200 St. Paul Street		23C. DATE SIGNED 10/27/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) cremation	24B. DATE 10/30/50	24C. NAME OF CEMETERY OR CREMATORY Green Mount Crematory	24D. LOCATION (City, town, or county) Baltimore, Maryland	(State)	
DATE RECEIVED BY LOCAL REGISTRAR 10/27/50	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR Wm. E. [Signature]		ADDRESS 1217 St. Paul Street	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 9223**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)**FLORENCE KEYS.**2. DATE
OF
DEATH**OCT 25, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND.B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION**1016 W. 38th ST.**

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1016 W 38th ST.c. Length of stay in Baltimore **LIFE**Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

FEMALE WHITE**WIDOW.**

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

AUG 9, 1875**75 75**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

HOUSEWIFE

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

MARYLAND.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

CALVIN STAMBAUGH.**SARAH DOBBS**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

LEROY L. KEYS-1016 W 38th ST18. **420.1**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis
Coronary Atherosclerosis**minutes**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Generalized Arteriosclerosis
Hypertension
Calcific Heart Disease**7****7**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **OCT. 17, 1945** to **OCT. 25, 1950** that I last saw the deceased alive on **Sept 27, 1950** and that death occurred at **4 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Kenneth E. Lusk**244 N. Hilton St.****10/26/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial**OCT 28/50****Poplar****Balto Co. Md**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 27 1950**Wm. H. H. H. H.****Therese E. Donovan 3818 Roland**

VS 150

094a

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9224**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PATRICK BOOKER			2. DATE OF DEATH October 25, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 15 Yrs. Yrs. 15 Mos. 0 Days 0			D. STREET ADDRESS (If rural, give location) 5636 Dove Court		
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1/9/1913		9. AGE (In years last birthday) 37
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY General Work	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Patrick Booker Sr			14. MOTHER'S MAIDEN NAME Emelia Johnson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		(If yes, give war or dates of service) War # 2	16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Sarah Waren 5613 Dove Court

18. **023X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Syphilitic heart disease with aortic insufficiency**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. Fisher

23B. CHIEF MEDICAL EXAMINER.....☒
ASSISTANT MEDICAL EXAMINER.....☐
M.D. MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Oct. 25, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/30/1950

Baltimore Nat. Cem.

Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

L-250

50 9225

REA-142188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9225

Registered No.

BIRTH NO. 50-21273

1. NAME OF DECEASED
(Type or Print)

Baby Girl Lawson-Palmetto

2. DATE
OF
DEATH

Oct. 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTIONBaltimore City Hosptials
4940 Eastern Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

4-02

D. STREET ADDRESS (If rural, give location)

318 Myrtle Avenue

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct. 3, 1950

9. AGE (In years
last birthday)

N. B.

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

12

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Anthony Pritchard

14. MOTHER'S MAIDEN NAME

Palmetto Lawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18. 762.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Fetal Atelectasis

12 Hrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 10-3 150, to 10-3 1950, that I last saw the
deceased alive on 10-3 1950, and that death occurred at 2:24 P. m., from the causes and on the date stated above.

23A. SIGNATURE

W. C. H.

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-5-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Cremation

24B. DATE

10-5-50

24C. NAME OF CEMETERY OR CREMATORY

B. C. H. Crematory

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 27 1950

STATE OF TEXAS

COUNTY OF _____

IN THE _____

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9226

Registered No.

50 9226

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sheffer, George F.

2. DATE
OF
DEATH

10-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

Baltimore City

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

28 0 0 Med. Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-20

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2805

Strathmore Ave

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Nov. 24-1882

9. AGE (In years last birthday)

67

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

machinist

10B. KIND OF BUSINESS OR INDUSTRY

machinery (M)

11. BIRTHPLACE (State or foreign country)

Glen Rock Pa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William H.B. Sheffer

14. MOTHER'S MAIDEN NAME

Barbara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Ms. Miller Sheffer 2805 Strathmore

18.

155X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinoma of bile ducts or gallbladder with extension, etc.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

(over)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 9-15 1950, to 10-25, 1950, that I last saw the deceased alive on 10-25, 1950, and that death occurred at 9:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Charles B. Buehler, Jr.

23B. ADDRESS

Univ. Hosp

23C. DATE SIGNED

10-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/28/50

24C. NAME OF CEMETERY OR CREMATORY

Morland Plk

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

10/27/50

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

J. J. Kunk - 5305 Harford Rd

ADDRESS

5305 Harford Rd

VS 150

5443L

46F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be stated correctly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

If possible, please state a more definite
anatomical location of the malignant tumor?

See Document File 50-9226 for report
in full

11-10-50

ES

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9227

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Jay Malcolm Phillips

2. DATE
OF
DEATH

10/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore

township)

c. Length of stay in Baltimore

30

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2834 Boarman Avenue #15

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

3-4-1893

9. AGE (In years

last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Sales man

10B. KIND OF BUSINESS OR
INDUSTRY

Sundry Supplies

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William S. Phillips

14. MOTHER'S MAIDEN NAME

Marion Mortimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-05-1693

17. INFORMANT

Erma D. (wife)

ADDRESS

as above

18. 42010

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Acute myocardial infarction

DUE TO

INTERVAL BETWEEN

ONSET AND DEATH

7 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease

DUE TO

unknown

(C) Hypertensive cardiovascular renal disease

unknown

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.Terminal bronchopneumonia
Chemia, chronic passive congestion

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-20, 1950 to 10-27, 1950, that I last saw the
deceased alive on 10/26, 1950 and that death occurred at 321A m., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louisa Candler

M. D.

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

10/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial Oct. 28/50

Mt. Olivet

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 28 1950

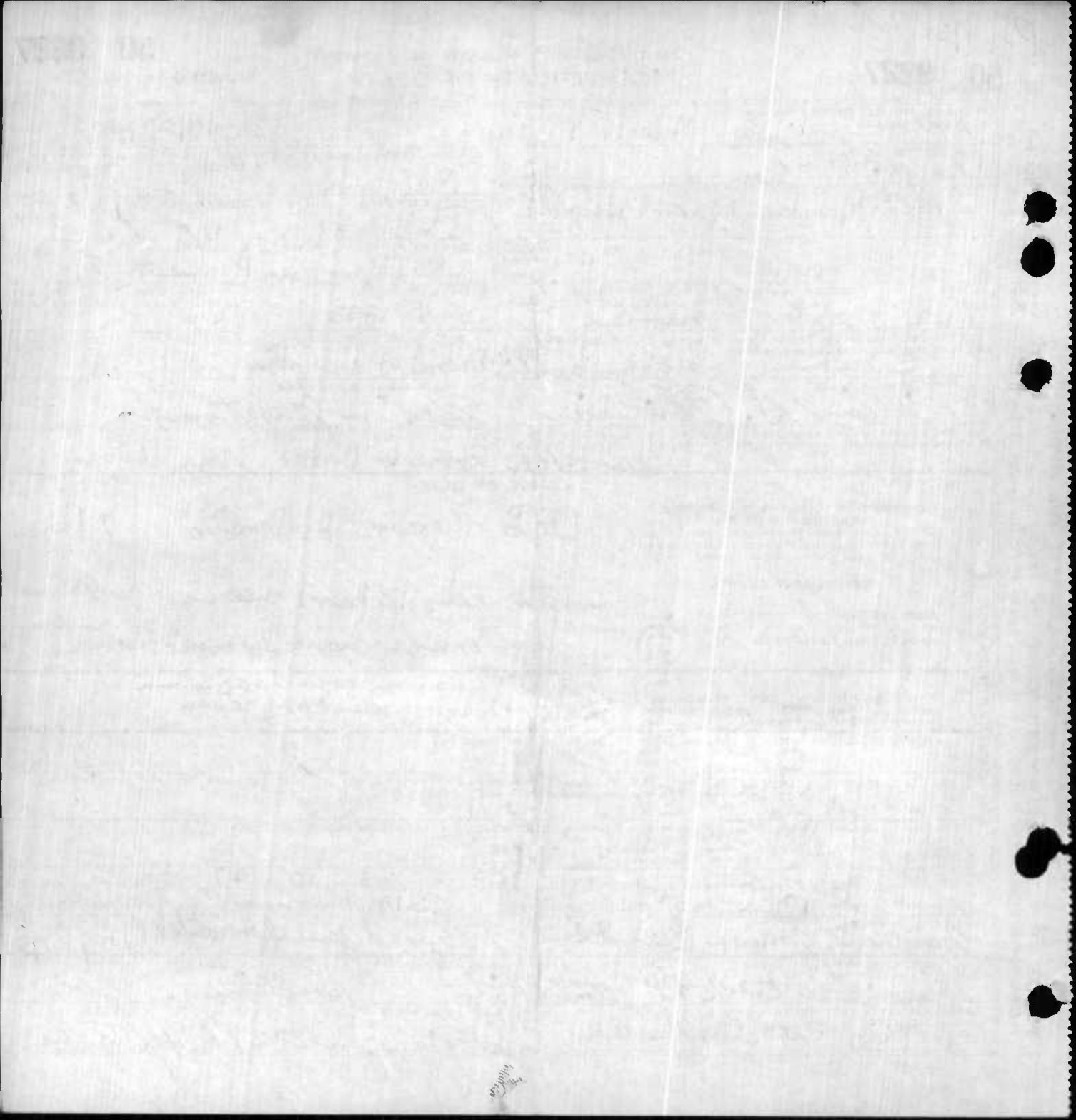
William S. Phillips, M.D.

Loring Byers 5005 Pk. Heights Ave

VS 150

49061

131a



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9228

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

C. IRENE BURROWS

2. DATE
OF
DEATH

Oct. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2404 Roslyn Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2404 Roslyn Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

NOV. 27, 1872

9. AGE (In years last birthday)

77

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Locke

14. MOTHER'S MAIDEN NAME

Laura Wolfe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

ADDRESS

Mr. William E. VanDreele 2404 Roslyn Ave.

18. 331x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *Cerebral-vascular hemorrhage*
DUE TO

7 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *hypertension*
DUE TO

years

(C) *Arterio-sclerosis, generalized*
DUE TO

years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to Oct. 26, 1950, that I last saw the deceased alive on Oct. 26, 1950, and that death occurred at 1:36 P. m., from the causes and on the date stated above.

23A. SIGNATURE

William E. VanDreele

M. D.

23B. ADDRESS

602 E. Preston Street

23C. DATE SIGNED

10/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/30/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

William E. VanDreele, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tuckner, Sons Inc. North Pa Ave

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

1900

ALBANY:

1901

PRINTED BY

THE STATE PRINTING OFFICE

ALBANY, N. Y.

1901

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1901

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1901

1901

1901

1901

1901

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9229
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) GARY FRITTER			2. DATE OF DEATH October 26, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Lutheran Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 450 Random Road		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 3, 1943		9. AGE (In years last birthday) 7 If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harvey Fritter			14. MOTHER'S MAIDEN NAME Ruby J. Cavey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT ADDRESS Mr. Harvey Fritter 450 Random Rd.		

18. E936.6 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Intra-cerebral hemorrhage DUE TO _____ (B) _____ DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) School		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) P.S.#71, Loudon Ave. & Old Frederick Rd.	
21D. TIME (Month) (Day) (Year) (Hour) October 24, 1950 3:00 P.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Struck head on desk	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>Stanley K. Deuelacher</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 10-27-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/30/50		24C. NAME OF CEMETERY OR CREMATORY Lorraine Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25. FUNERAL DIRECTOR ADDRESS Mr. J. Pickens, Sons Inc North Pa.			
DATE RECEIVED BY LOCAL REGISTRAR OCT 28 1950		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>			

V S 151

N-855.0

186a ✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

PAID TO THE CITY OF BOSTON

1911

1911

1911

DATE OF DEATH

1911

1911

1911

1911

1911

1911

1911

1911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9230

50 9230

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Annie Barbara McCleary</i>			2. DATE OF DEATH <i>10-27-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Hospital for Women of Maryland</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore Yrs. <i>47</i> Mos. <i>11</i> Days <i>12</i>			D. STREET ADDRESS (If rural, give location) <i>302 Thornhill Road</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>4-29-1868</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Year Months: <i>82</i> Days: <i>82</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13. FATHER'S NAME <i>Henry McCleary</i>			14. MOTHER'S MAIDEN NAME <i>Thyane MARY</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT ADDRESS <i>Mrs Howard Schnepf 302 Thornhill Rd Balto. Md.</i>		
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>I</i> <i>Acute Myocardial Infarction</i> DUE TO <i>7 hours</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 hours</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i> <i>Hypertensive Cardiovascular disease</i> <i>Arteriosclerotic Cardiovascular disease</i>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10-26</i> , 1950, to <i>10-27</i> , 1950, that I last saw the deceased alive on <i>10-27</i> , 1950, and that death occurred at <i>2:45 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Walter E. Greenleaf</i>		23B. ADDRESS <i>Waverly Hospital</i>		23C. DATE SIGNED <i>10-27-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-30-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MORELAND MEMORIAL CEM</i>	
24D. LOCATION (City, town, or county) <i>BALTO MD</i>		24E. FUNERAL DIRECTOR <i>Wm J. Deane Sons Inc Balto Md.</i>		24F. ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 28 1950</i>		REGISTRAR'S SIGNATURE <i>Wm J. Deane</i>		25. FUNERAL DIRECTOR <i>Wm J. Deane Sons Inc Balto Md.</i>	

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9231
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William L. Bridle

2. DATE
OF
DEATH

Oct. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Md.

5. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hospital (Dor)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

6. STREET ADDRESS (If rural, give location)

2109 Denison St.,

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Separated

8. DATE OF BIRTH

Oct. 5, 1885

9. AGE (In years
last birthday)

65

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William L. Bridle, Sr.

14. MOTHER'S MAIDEN NAME

Emily Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Marie Bridle 2109 Denison St.,

18. 42011

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Disease

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, J.

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct. 26, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-28-1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore,

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Kammer, J.

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.,

VS 151

97093

094a

✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MSU

MSU



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9232

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SIMON, Willie

2. DATE
OF
DEATH

10/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

md

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Provident

C. CITY OR TOWN (If outside corporate limits, write BURIAL and give township)

Baltimore

16-03

D. STREET ADDRESS (If rural, give location)

701 N. Fulton

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11/5/10

9. AGE (In years last birthday)

39 40

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

STEEL MILL

11. BIRTHPLACE (State or foreign country)

Bishopville S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Tom Simon

14. MOTHER'S MAIDEN NAME

Mamie Haynesworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Hosp. Records

ADDRESS

18. 521X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Embolism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Lung Abscess

DUE TO

(C) Pulmonary edema

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/20/1950 to 10/25/1950 that I last saw the deceased alive on 10/25/1950, and that death occurred at 11:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

John W. Holmes III

M. D.

23B. ADDRESS

Provident Hosp.

23C. DATE SIGNED

10/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-29-50

24C. NAME OF CEMETERY OR CREMATORY

Arlington

24D. LOCATION (City, town, or county) (State)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

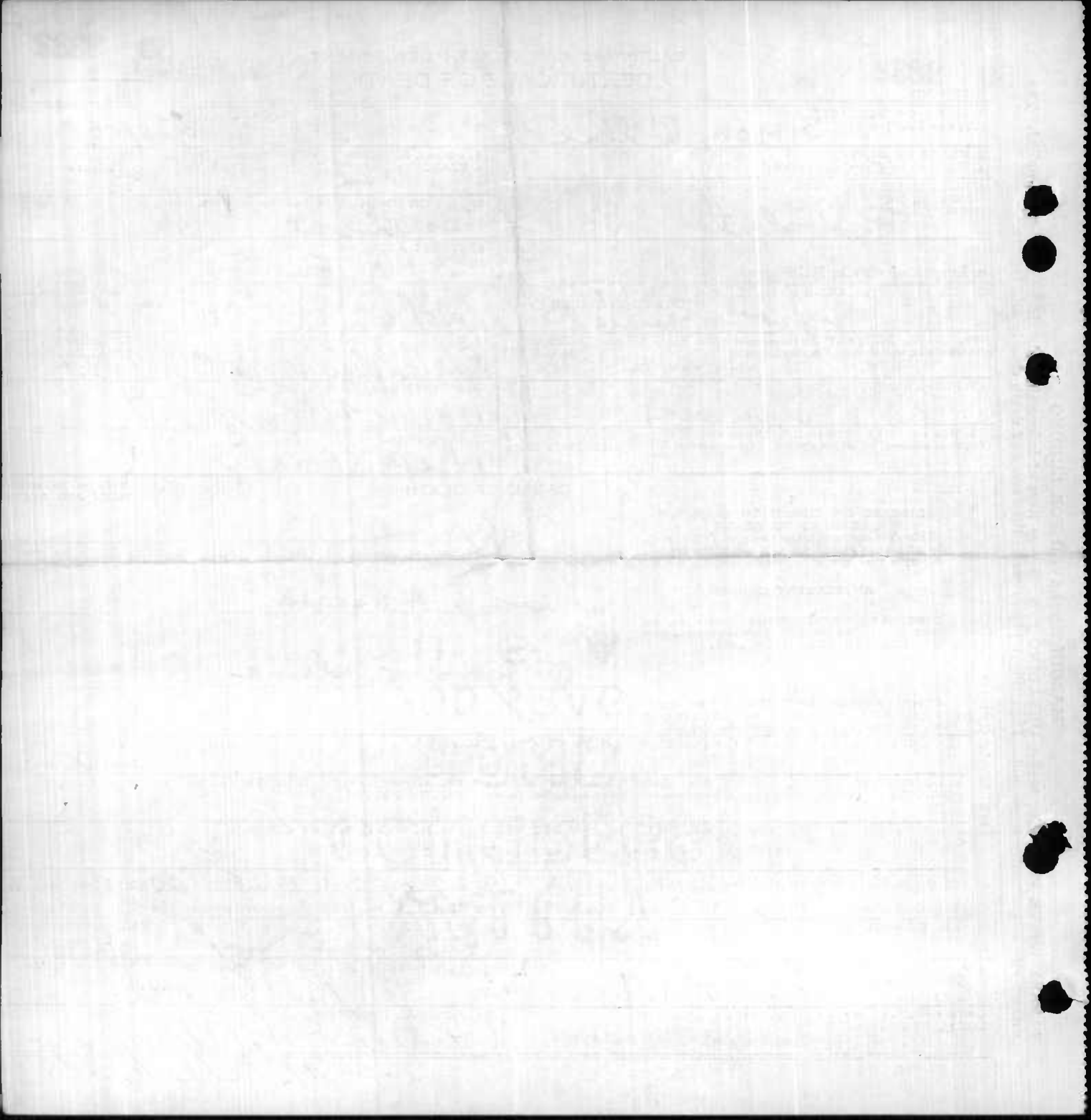
Linton Williams, M.D.

25. FUNERAL DIRECTOR

Charles H. Alexander

ADDRESS

1200 W. Cullum St.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 10-30-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9233
Registered No.

B-653
50 9233
BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY BRYANT			2. DATE OF DEATH October 26, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1503 Mosher Street		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1893	9. AGE (In years last birthday) 57 55	H Under 1 Year Months Days H Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY GENERAL	11. BIRTHPLACE (State or foreign country) Boston, Mass.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-09-4921	17. INFORMANT ADDRESS Isabelle Johnson 811 Whitcomb St.		

18. 443 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease (A) Hypertensive cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Insp. & Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William V. ...</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 10-26-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Buried	24B. DATE 10/28	24C. NAME OF CEMETERY OR CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 28 1950		REGISTRAR'S SIGNATURE <i>Wm. H. Williams, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS Eugene H. Woyos - 825 Harlem Ave. Baltimore, Md. - 93	

V S 151

97099

3833 30

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

3833

Name of deceased		Sex		Age	
Date of death		Time of death		Place of death	
Cause of death		Disease		Occupation	
Signature of physician		Signature of registrar		Signature of informant	

CAUSE OF DEATH

Immediate cause		Intermediate cause		Underlying cause	
Duration of illness		Duration of disease		Duration of symptoms	
Signature of physician		Signature of registrar		Signature of informant	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9234
Registered No. _____

620
50 9234
BIRTH NO.

1. NAME OF DECEASED (Type or Print) LYNN (Evelyn) Harris			2. DATE OF DEATH 10-21-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Ind. B. COUNTY city.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital			C. CITY OR TOWN (If outside corporate limits, write FULL and give township) Baltimore		
C. Length of stay in Baltimore 1943 Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 110-W. 23rd St.		
5. SEX M.	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 17/1908	9. AGE (In years last birthday) 42	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) meter reader		10B. KIND OF BUSINESS OR INDUSTRY San. Lab. Co.	11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Harris			14. MOTHER'S MAIDEN NAME Bessie Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 251-01-4114	17. INFORMANT'S ADDRESS Thornie Harris - Farmat Ave.		
18. 022X CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Syphilitic Aneurysm of Aorta with Rupture with Hemorrhage into left pleural cavity					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE William W. ...			23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 10-22-50
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 10/28/50	24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Cedar Hill Ind.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 28 1950		REGISTRAR'S SIGNATURE Wm. ...		25. FUNERAL DIRECTOR W. ... ADDRESS 390 54 ...	

Was the aneurysm of aorta
suppurative in origin?

W-460
50 9235

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9235

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLAIRE S. WHEELER

2. DATE
OF
DEATH 10/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3911 Fourth Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3911 Fourth Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

9/2/1879

9. AGE (In years
last birthday)

71

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas H. Stavely

14. MOTHER'S MAIDEN NAME

Mary I. Hodges

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Artery Disease

1 yr.

DUE TO

ANTECEDENT CAUSES

(B)

Coronary Occlusion

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1950, to Oct 24, 1950, that I last saw the
deceased alive on 10/24, 1950, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Vincent M. Messina

M. D.

23B. ADDRESS

1403 S. Charles St

23C. DATE SIGNED

10/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

B

24B. DATE

10/28/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore

ADDRESS

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

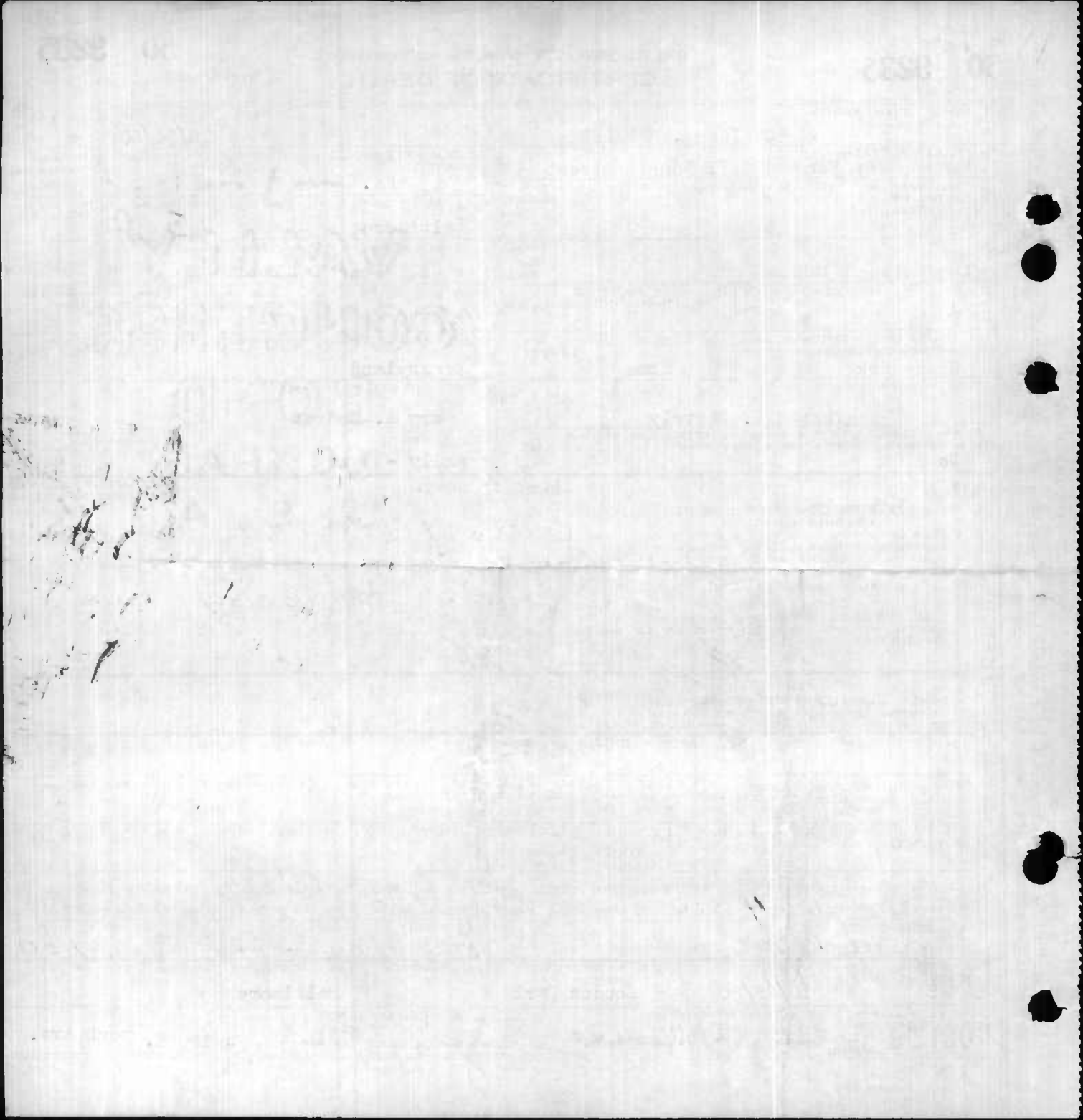
25. FUNERAL DIRECTOR

James L. Lee

- 130 E. Port Ave.

VS 150

094a



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9236

Registered No.

50 9236

1. NAME OF DECEASED (Type or Print) CHARLES MARION HIGGINS JR.		2. DATE OF DEATH 10/26/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY a. a.	
5. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSP.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 101 Fifth Ave # 25	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 11.1.1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Supt.		10B. KIND OF BUSINESS OR INDUSTRY Con. Air Co.	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Higgins		14. MOTHER'S MAIDEN NAME Eliz. Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO.	
17. INFORMANT Stanning Lane		ADDRESS	

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis DUE TO hypertensive arteriosclerotic cardiac vascular disease	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

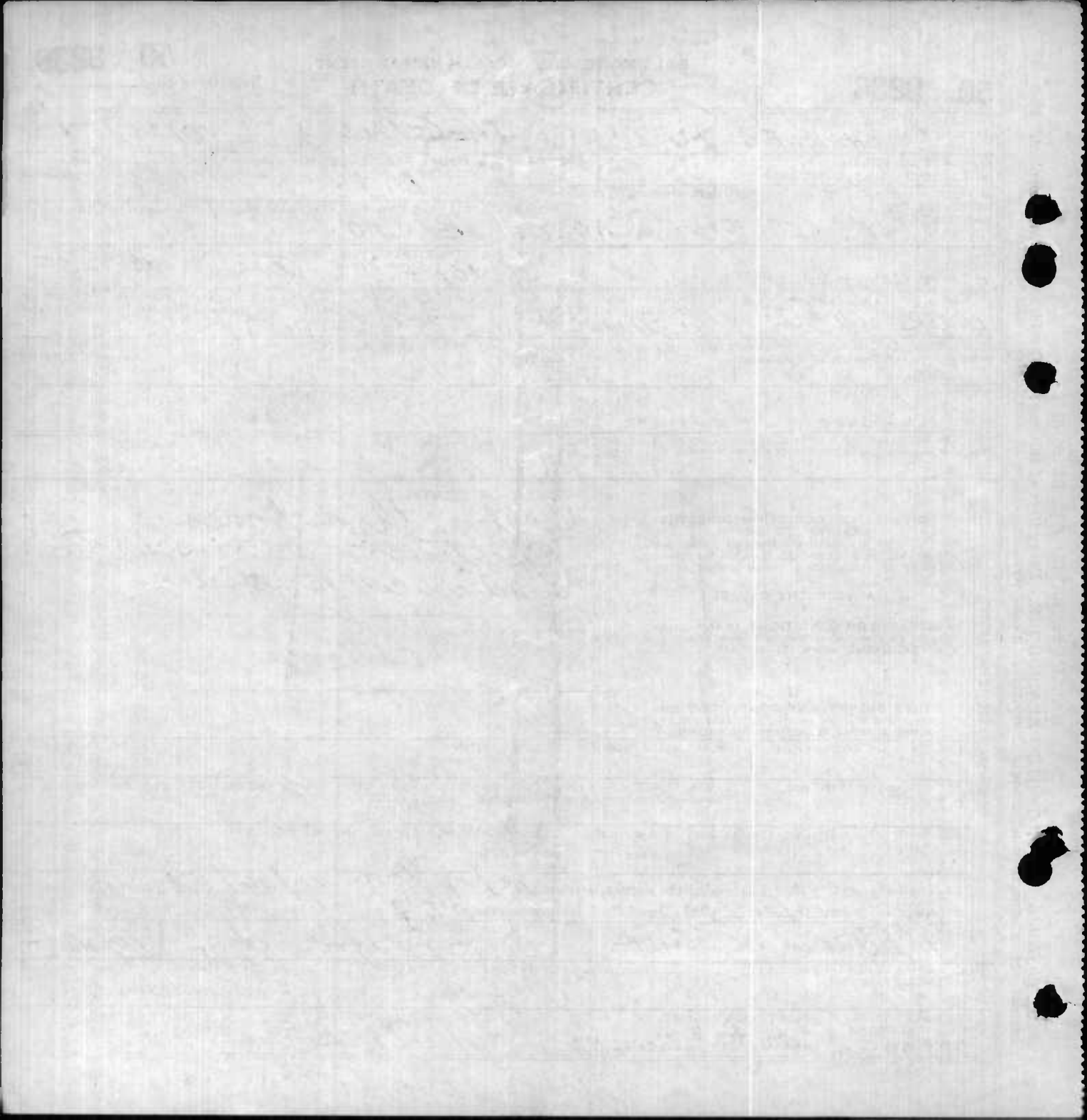
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK AT <input type="checkbox"/> WORK	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 10/18/50 , to 10/26/50 , that I last saw the deceased alive on 10/26/50 , and that death occurred at 7:12 m., from the causes and on the date stated above.				
23A. SIGNATURE Thaddeus Swinski		23B. ADDRESS St. Joseph's Hosp.		23C. DATE SIGNED 10/26/50
24A. BURIAL, CREMATION, REMOVAL (Specify) B.	24B. DATE 10.30.50	24C. NAME OF CEMETERY OR CREMATORY Cedar Hill	24D. LOCATION (City, town, or county) (State) Baltimore	
DATE RECEIVED BY LOCAL REGISTRAR OCT 28 1950	REGISTRAR'S SIGNATURE Timothy Williams, M.D.	25. FUNERAL DIRECTOR James H. De Cury		

29066 130 E. Towson Ave. 093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9237

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William C.

Bitzer

2. DATE
OF
DEATH

10/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

2907. Walbrook Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

St Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Maryland

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

10-4-1886

9. AGE (In years
last birthday)

64

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

DRAFTSMAN

10B. KIND OF BUSINESS OR
INDUSTRY

STEEL (M)

11. BIRTHPLACE (State or foreign country)

PA.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Bitzer

14. MOTHER'S MAIDEN NAME

Caroline Yeager

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 466X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Mesenteric Venous Thrombosis

DUE TO

1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.Bronchopneumonia bilateral
& auricular fibrillation5 days
1 day

19A. DATE OF OPERATION

10/28/50

19B. MAJOR FINDINGS OF OPERATION

Mesenteric Venous Thrombosis

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 20, 1950, to Oct 28, 1950, that I last saw the
deceased alive on Oct 28, 1950, and that death occurred at 2:20 A. M., from the causes and on the date stated above.

23A. SIGNATURE

W. McGonray

23B. ADDRESS

St Agnes Hospital Baltimore

23C. DATE SIGNED

10/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10-30-50

24C. NAME OF CEMETERY OR CREMATORY

Ivy Hill

24D. LOCATION (City, town, or county)

Phila. PA.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

Wm. McGonray

25. FUNERAL DIRECTOR

John O. Mitchell & Sons 1900 Eutaw Place

ADDRESS

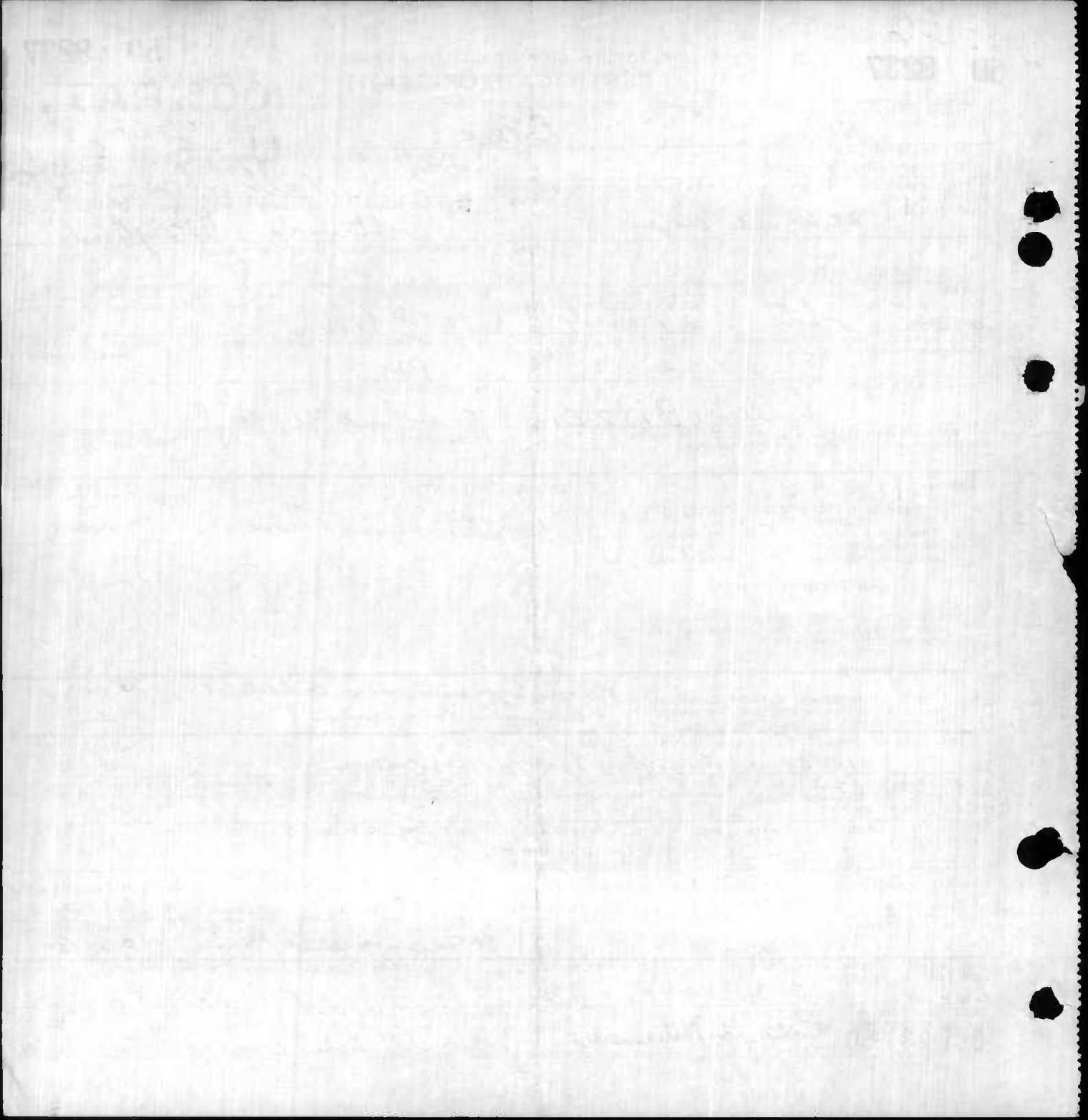
VS 150

0353D

100. b

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9238
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) WILLIAM GREEN			2. DATE OF DEATH October 26, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
5. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
6. Length of stay in Baltimore 3 Years			D. STREET ADDRESS (If rural, give location) 906 N. Stricker Street		
7. SEX Male	8. COLOR OR RACE Colored	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	10. DATE OF BIRTH		11. AGE (In years last birthday) 31
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) N. C.	
13. FATHER'S NAME Robert Green			14. MOTHER'S MAIDEN NAME Laura Ann		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT June Green	
				ADDRESS 906 N. Stricker St.	

18. E981 x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Tetanus DUE TO gunshot wound of left thigh		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO _____		
(C) DUE TO _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) a home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1155 Whatcoat Street	
21D. TIME (Month) (Day) (Year) (Hour) October 14, 1950 10 A. m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Firearms	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley K. Dunsen		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED 10-27-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Removed		24B. DATE 10/28/50		24C. NAME OF CEMETERY OR CREMATORY Rocky Mount, No. Caroline	
DATE RECEIVED BY LOCAL REGISTRAR OCT 28 1950		REGISTRAR'S SIGNATURE Wm. J. Williams, Jr.		25. FUNERAL DIRECTOR Wm. J. Williams, Jr.	
				ADDRESS 927 N. Mount St.	

V S 151 N 890.4 97024 166.0 Mount St.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

8592 02

CERTIFICATE OF DEATH

CAUSE OF DEATH

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9239
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY E. GEIGAN

2. DATE
OF
DEATH

10/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1012 E. North Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1012 E. North Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

1869

9. AGE (In years, last birthday)

81

10 Under 1 Year Months Days 11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John J. Geigan

14. MOTHER'S MAIDEN NAME

(?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

-

17. INFORMANT

ADDRESS

Mrs. Howard Wright 1012 E. North Ave

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Arteriosclerotic Cardio-vascular Disease

4 yrs

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-24, 1940 to 10-25, 1950, that I last saw the deceased alive on 10-26, 1950, and that death occurred at 5 a. m., from the causes and on the date stated above.

23A. SIGNATURE

P. D. Flynn

23B. ADDRESS

11 E. Chase St

23C. DATE SIGNED

10-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/30/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

W. J. Williams and Son
1012 E. North Ave. & 22nd St.

ADDRESS

50 H. P.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9240
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY BRANAN

2. DATE OF DEATH
10/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2206 Cecil Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
2206 Cecil Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1860

9. AGE (In years, last birthday)

90

If Under 1 Year Months Days
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Fleschman

14. MOTHER'S MAIDEN NAME

(?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

-

17. INFORMANT

ADDRESS

Mrs. David McCourt 2208 Cecil Avenue

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis generalised

DUE TO

years.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1947, to Oct. 26, 1950 that I last saw the deceased alive on Oct. 25, 1950, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/28/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem

24D. LOCATION (City, town, or county)

City

DATE RECEIVED BY LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

Walter J. Williams, M.D.

25. FUNERAL DIRECTOR

WILKELFELD AND SON

ADDRESS

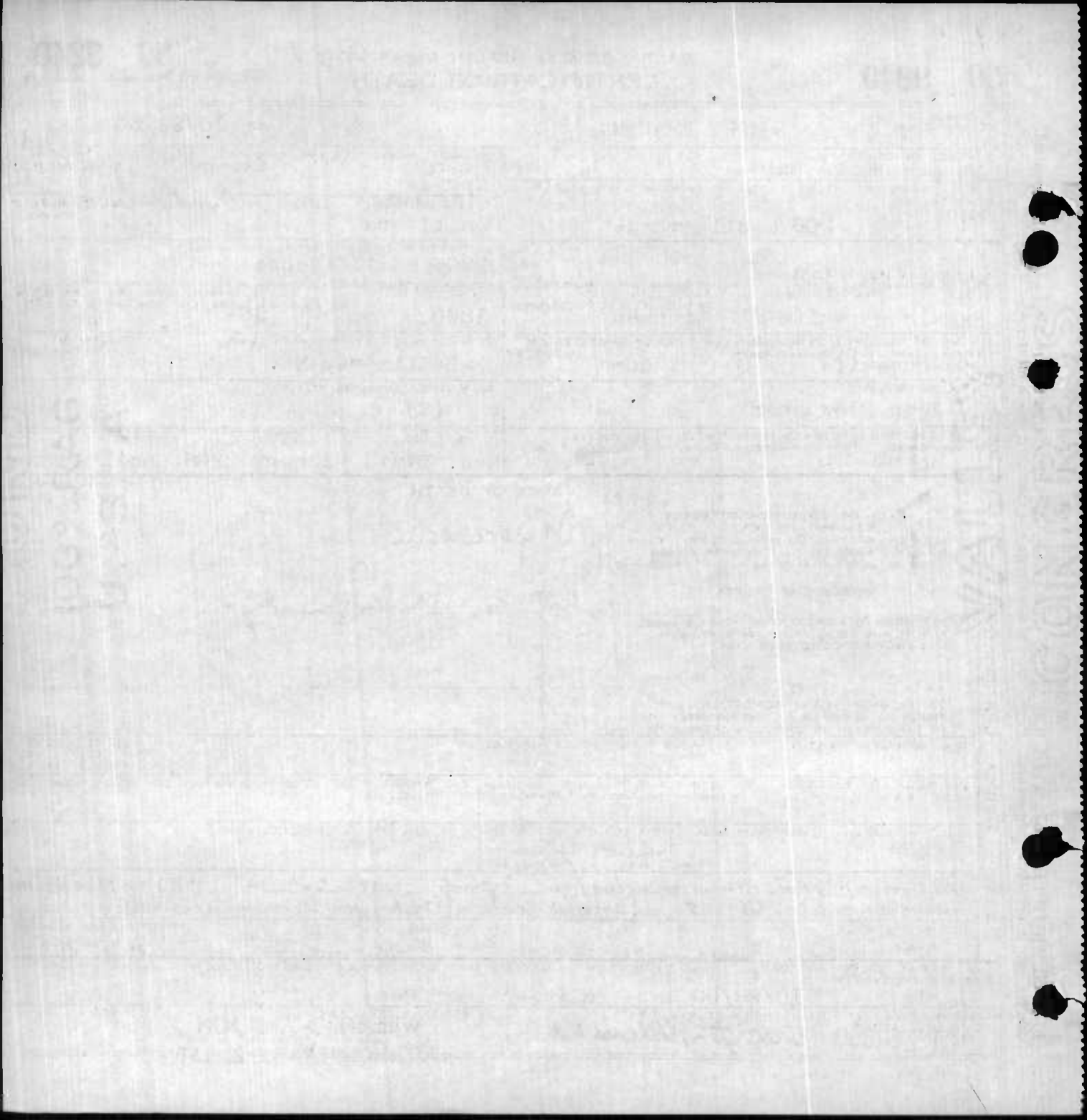
GREENMOUNT AVE. & 22ND ST.

VS 150

0932

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5-152
50 9241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9241

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Amanda D. Spencer</i>		2. DATE OF DEATH <i>10/26/50</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY _____	
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>2508 Guilford Ave</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		d. STREET ADDRESS (If rural, give location) <i>2508 Guilford Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/17/1868</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	9. AGE (In years last birthday) <i>82</i>
11. BIRTHPLACE (State or foreign country) <i>N. Y.</i>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>John Callen</i>		14. MOTHER'S MAIDEN NAME <i>(Unknown) Green</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Raymond D. Spencer</i>		18. ADDRESS <i>18557 Oak Ave Detroit Mich.</i>	

18. <i>180X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of right kidney</i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 10 months</i>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>none</i>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>none</i>		

19A. DATE OF OPERATION <i>10/26/50</i>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>9/26/50</i> , to <i>10/26/50</i> , 1950, that I last saw the deceased alive on <i>10/26/50</i> , and that death occurred at <i>7:45 P.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Geo. W. Murga</i>		23B. ADDRESS <i>401 E. 25th. Street</i>		23C. DATE SIGNED <i>10/28/50.</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>10/29/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Maple Grove</i>	
24D. LOCATION (City, town, or county) (State) <i>Friendship N. Y.</i>		25. FUNERAL DIRECTOR <i>Wm. Cook Inc. 1217 St. Paul St.</i>			

DATE RECEIVED BY LOCAL REGISTRAR
Oct 28 1950
VS 150

05ra

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9242

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JOSEPH R. BORACKI - BROWN

2. DATE
OF

DEATH **October 26, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

905 Fell Street

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

905 Fell Street

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 19, 1895

9. AGE (In years
last birthday)

55

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Maintenance Man

10B. KIND OF BUSINESS OR
INDUSTRY

Can Mfg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Boracki

14. MOTHER'S MAIDEN NAME

Anna Kuczynska

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-09-6020

17. INFORMANT

ADDRESS

Mrs. Mary Boracki, 905 Fell Street

18. **002X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) _____

DUE TO _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) _____

DUE TO _____

(C) _____

INTERVAL BETWEEN
ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 1950** to **Oct 26, 1950**, that I last saw the
deceased alive on **Oct 25, 1950** and that death occurred at **8:40** pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/30/50

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus

24D. LOCATION (City, ~~TOWNSHIP~~ COUNTY) (State)

Baltimore, Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Arthur J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

M. P. Sadowski & Sons, 1803 Eastern Avenue

VS 150

5543D

Charles W. Sadowski

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 10-30-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9243

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Margaret M. Ballman

2. DATE
OF
DEATH

26
10-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

103 N. Potomac St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

103 N. Potomac St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

6-23-1902

9. AGE (In years
last birthday)

48

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Factory worker

10B. KIND OF BUSINESS OR
INDUSTRY
Refrigeration

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James O'Keefe

14. MOTHER'S MAIDEN NAME

Mabel Carrall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

219003-5610

17. INFORMANT

ADDRESS

Daniel R. Ballman 103 N. Potomac St

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

CAUSE OF DEATH

Pulmonary edema

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Carcinomatosis

DUE TO

(C)

Cancer, head of pancreas

INTERVAL BETWEEN
ONSET AND DEATH

6 weeks

(over)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

9-25-50

19B. MAJOR FINDINGS OF OPERATION

generalized carcinoma

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950, to Oct 26, 1950, that I last saw the deceased alive on Oct 26, 1950, and that death occurred at 11:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles B. MacMillan

23B. ADDRESS

2900 E. Baltimore St

23C. DATE SIGNED

Oct 28, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-30-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

Walterton Williams, M.D.

25. FUNERAL DIRECTOR

John R. Moran

ADDRESS

3000 E. Baltimore St.

VS 150

6903L

469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

If possible, please state a more definite
anatomical location of the malignant tumor?

See Document File 50-9243

20

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9244

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

AGNES

JUNGGUST

2. DATE
OF
DEATH

October 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

Yrs.
Mos.
Days
Life

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

21 N. Streeper Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1-16-1909

9. AGE (In years
last birthday)

41

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Ramault

14. MOTHER'S MAIDEN NAME

Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Joseph T. Junggust

ADDRESS 21 N.

Streeper St.

18. E9771.7

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute fluoride poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21 N. Streeper Street

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

October 27, 1950 2:00A.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingestion of fluoride poisoning

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct. 27, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-31-50

24C. NAME OF CEMETERY OR CREMATORY

Oaklawn

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 28 1950

William Williams, M.D.

John A. Moran

3000 E. Baltimore St.

VS 151

N979.0

1639

✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Saylor E-245
3902 Greenmount 50 9245

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9245

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ella Ida Eslinger

2. DATE
OF
DEATH

Oct. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

637 E. 37th St.

C. CITY OR TOWN

Maryland

Baltimore

9-03

D. STREET ADDRESS (If rural, give location)

637 E. 37th St.

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years, last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

married

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Hogg

14. MOTHER'S MAIDEN NAME

Elizabeth Leutbecker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Joseph Eslinger - 637 E 37th

18. 153x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of Caecum

10 mo.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

April 7, 1950

Carcinoma of Caecum

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan. 1950, to Oct. 26, 1950, that I last saw the deceased alive on Oct. 26, 1950, and that death occurred at 2:15 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Lloyd E. Saylor

23B. ADDRESS

3902 Greenmount Ave.

23C. DATE SIGNED

Oct. 27, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/30/50

24C. NAME OF CEMETERY OR CREMATORY

Oaklawn

24D. LOCATION (City, town, or county)

Balto Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

L. J. Luck - 5305 Hayford Rd.

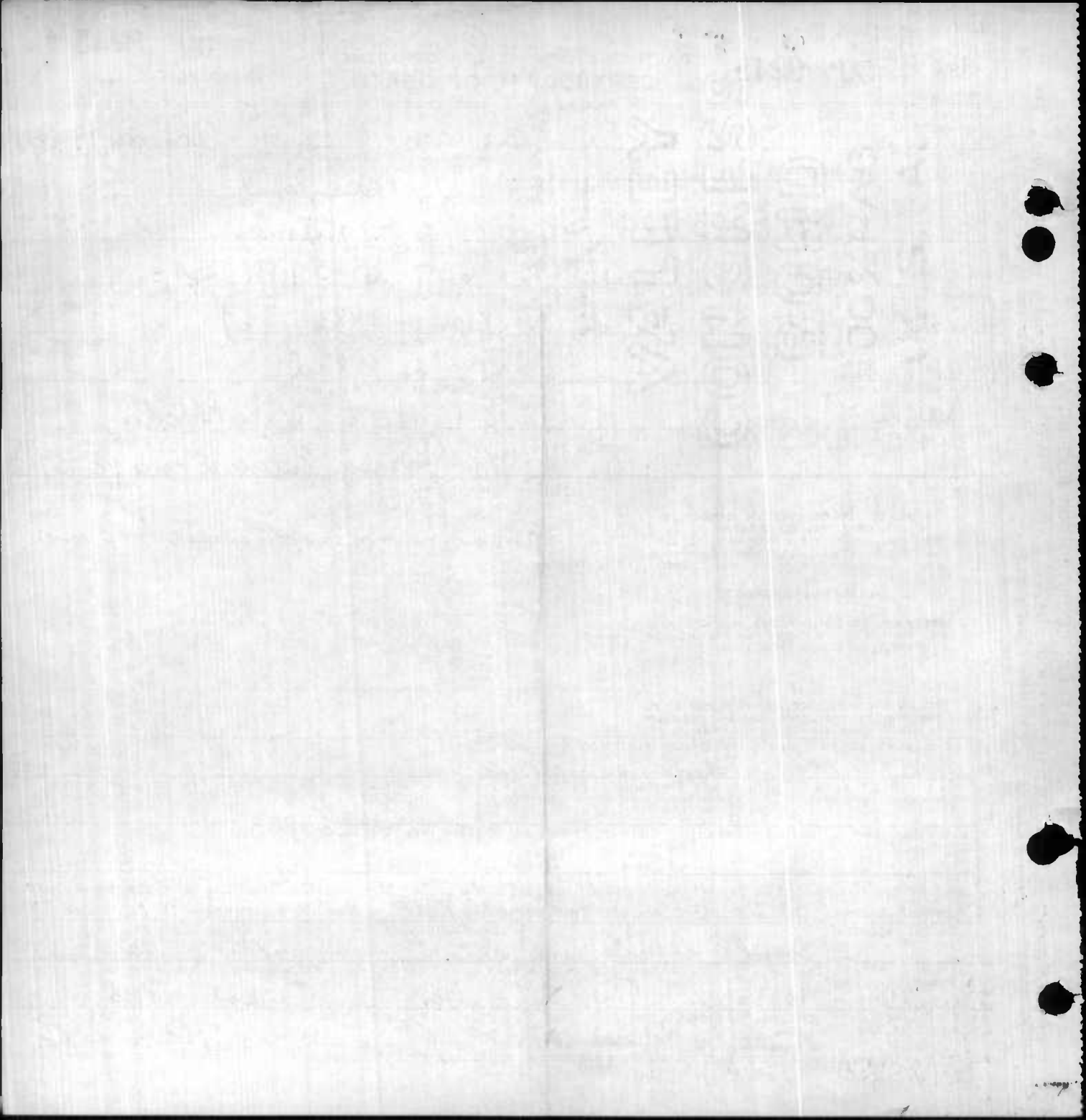
ADDRESS

OCT 28 1950

0462

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Traugott 50 9246
1623 E. North P-361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louise Pittroff

2. DATE OF DEATH

Oct. 25-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

8. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

4700 Harford Rd

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4700 Harford Rd

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 21-1869

9. AGE (In years, last birthday)

81

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bald Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Zimmerman

14. MOTHER'S MAIDEN NAME

Mary Schoenthaler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Mrs. V. Lehberger - 3013 Harman

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Crownary thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

arteriosclerosis

(C)

port. incom p. + stenosis

INTERVAL BETWEEN ONSET AND DEATH

Unknown

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from April 1948, to October, 1950, that I last saw the deceased alive on August 19, 1950, and that death occurred at 12.1 p.m., from the causes and on the date stated above.

23A. SIGNATURE

K. Traugott

23B. ADDRESS

1623 E. N. Overmire

23C. DATE SIGNED

10/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 29 1950

Huntington Williams, M.D.

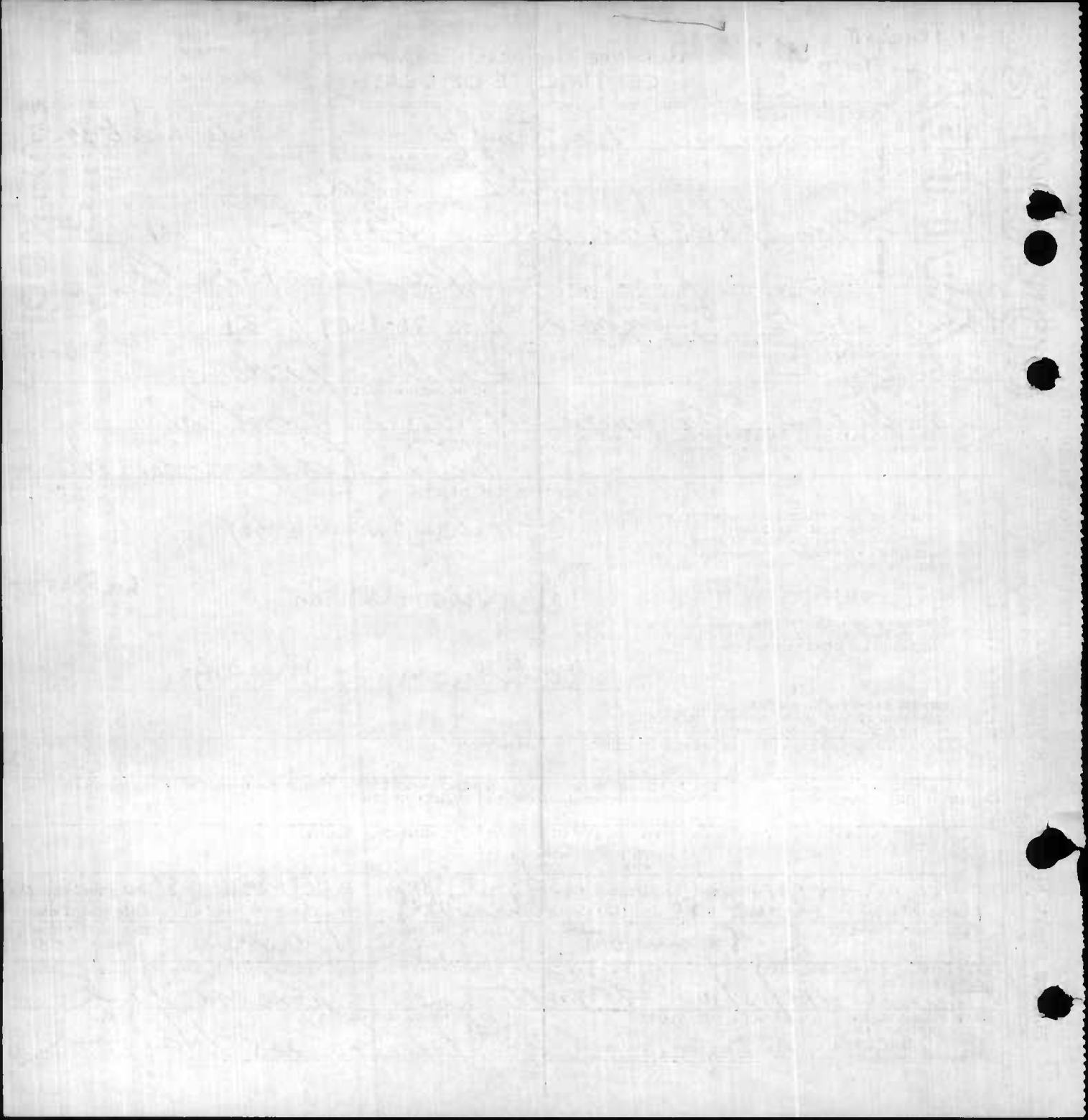
Thick - 5305 Harford

VS 150

092a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly applied. The correct age is especially important. Physicians: please write the causes of death.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9247

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ADA VIRGINIA JOHNSON

2. DATE
OF
DEATH

10-28-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

PROVIDENT HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

BALTIMORE (17) 17-02

D. STREET ADDRESS (If rural, give location)

1315 BRUNT ST.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

NEGRO

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED - SEP.

8. DATE OF BIRTH

2-15-21

9. AGE (In years
last birthday)

29

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

UNEMPLOYED

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

CAMBRIDGE, MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

EARL WHITTINGTON

14. MOTHER'S MAIDEN NAME

SOPHIE ENNELLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MOTHER

1315 BRUNT ST.

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

CHRONIC GLOMERULONEPHRITIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

CARDIO
HYPERTENSIVE RENAL DISEASE

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) SECOND

SECONDARY ANEMIA

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-27, 1950, to 10-28, 1950, that I last saw the
deceased alive on 10-28, 1950, and that death occurred at 6:55 PM from the causes and on the date stated above.

23A. SIGNATURE

J. H. Piskney M.D.

23B. ADDRESS

Provident Hosp.

23C. DATE SIGNED

10-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION City, town, or county

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

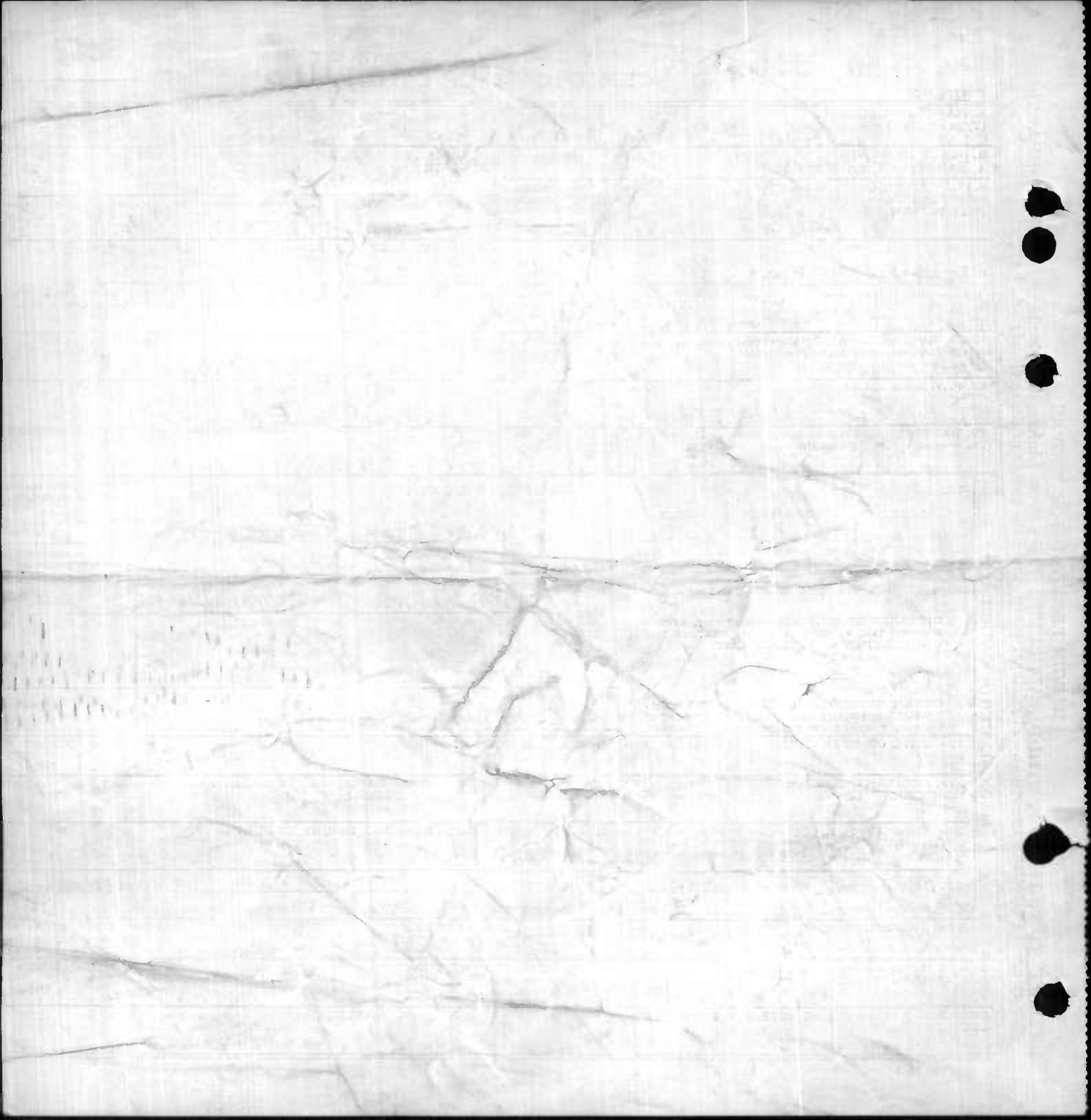
OCT 29 1950

VS 150

M. H. Williams, M.D.

Dwight H. Bayne 301 West 1st St.

131a



H-240

REA-141788

50 9248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9248

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Frances Tyler Hoshall			2. DATE OF DEATH Oct. 27, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 31 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-10		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 706 Winston Avenue		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 1, 1919	9. AGE (In years last birthday) 31	10. UNDER 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? ✓		
13. FATHER'S NAME Caleb Tyler			14. MOTHER'S MAIDEN NAME Lilly S. Dean		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Records: B. C. H. 4940 Eastern Avenue			ADDRESS		

18. 080.0	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 weeks
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Polio myelitis (bulbar form) (crisis history)	
DUE TO			
ANTECEDENT CAUSES		(B) _____	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO	
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-19- , 1950 , to 10-27- , 1950 , that I last saw the deceased alive on 10-27- , 1950 , and that death occurred at 10:45 Pm. , from the causes and on the date stated above.					
23A. SIGNATURE J. H. Rogers		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 10-28-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 31-1950		24C. NAME OF CEMETERY OR CREMATORY Greenmount	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md		25. FUNERAL DIRECTOR Wmnd Cook Inc - 1217 St Paul	
DATE RECEIVED BY LOCAL REGISTRAR OCT 29 1950		REGISTRAR'S SIGNATURE Wmnd Cook		ADDRESS 1217 St Paul	

VS 150

036.0

MARGIN RESERVED FOR BINDING
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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10

RECEIVED BY DEPARTMENT OF DEFENSE

8152

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0706210

K-520
50 9249BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 9249
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ottillie M. Kneis

2. DATE
OF DEATH October 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4703 Hampnett Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River

D. STREET ADDRESS (If rural, give location)

Middleborough

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 10, 1893

9. AGE (In years last birthday)

57

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Adolph Meyers

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

William M. Kneis, Fred Avon Rd. Middle

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-vascular disease

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from October 19, 1950, to October 26, 1950, that I last saw the deceased alive on October 19, 1950, and that death occurred at 9:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Albert C. Hermann

M. D.

2921 E. Federal St.

10-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

10/30/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Baltimore

(State)

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

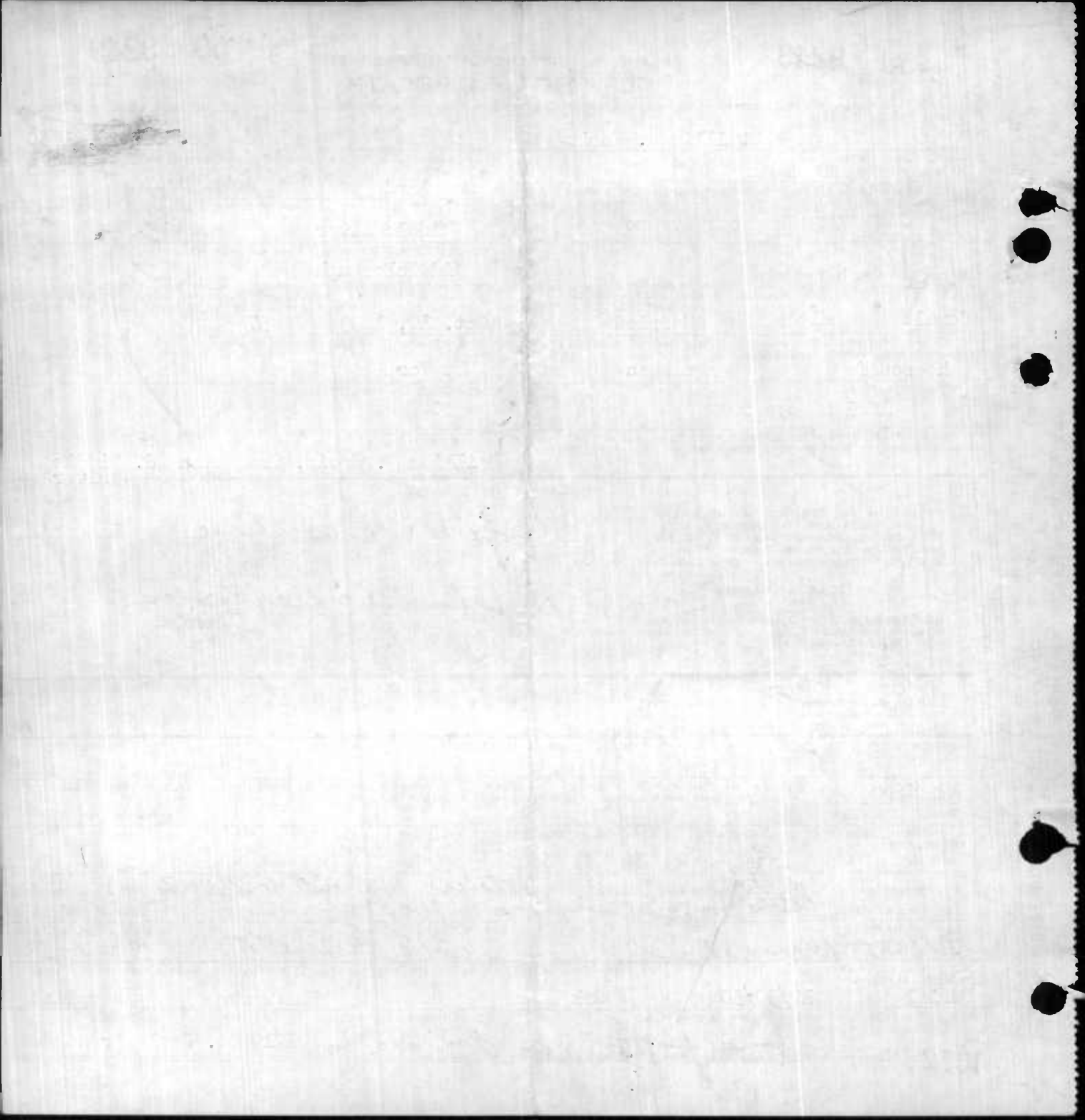
ADDRESS

OCT 29 1950

Huntington Williams & Co.

Wm. G. G. Inc. 1217 St. Paul Street

093 d



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9250
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MIRIAM BLOCK

2. DATE
OF
DEATH

10-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1423 East Balto St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 3-01

D. STREET ADDRESS (If rural, give location)

1423 E. Baltimore St

c. Length of stay in Baltimore

45 Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

10-27-50

9. AGE (In years last birthday)

45

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Shea

Drigent

14. MOTHER'S MAIDEN NAME

Dora

15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Charles Block -

ADDRESS

Home

18. 42010

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Intracardiac Heart Disease with coronary artery disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Oct. 26th, 1952, to Oct. 27th, 1952, that I last saw the deceased alive on Oct. 27th, 1952, and that death occurred at 7 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Katharine R. King

23B. ADDRESS

20 E Preston St

23C. DATE SIGNED

10/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-29-50

24C. NAME OF CEMETERY OR CREMATORY

Wooddale

24D. LOCATION (City, town, or county)

Balto

(State)

MD

DATE RECEIVED BY LOCAL REGISTRAR

OCT 28 1950

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

Jack Kewick

ADDRESS

2100 Eastwood Pl

VS 150

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Kemp
206
Preston
12-2

4-110

50 9251

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9251

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>SOPHIE Lebov</i>		2. DATE OF DEATH <i>16-28-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>16-07</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>LUTHERAN Hospital of Md</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTO</i>	
c. Length of stay in Baltimore <i>30</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2900 Pressman St 16</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>m</i>	8. DATE OF BIRTH <i>May 1897</i>
9. AGE (In years last birthday) <i>53</i>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Saved</i>		14. MOTHER'S MAIDEN NAME <i>Etta</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Self. Sol Lebov</i>		ADDRESS <i>Same</i>	
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>(A) Pulmonary edema</i> DUE TO <i>(B) Anterolateral Myocardial Infarct</i> DUE TO <i>(C) ACVD.</i>		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10-27</i> , 19 <i>50</i> , to <i>10-28</i> , 19 <i>50</i> that I last saw the deceased alive on <i>10-28</i> , 19 <i>50</i> , and that death occurred at <i>2:50</i> p.m., from the causes and on the date stated above.			
23A. SIGNATURE <i>John C. Hyle</i>		23B. ADDRESS <i>Lutheran Hospital</i>	
23C. DATE SIGNED <i>10-28-50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-29-50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Herring Run</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 29 1950</i>		REGISTRAR'S SIGNATURE <i>William Williams</i>	
25. FUNERAL DIRECTOR <i>Jack Lewis</i>		ADDRESS <i>2100 Eutan Pl</i>	

1258

RECEIVED

1258



5-632
50 9252Medical Examiners Case
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9252

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Winnie Swartz

2. DATE
OF
DEATH

10/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

township)

D. STREET ADDRESS (If rural, give location)

2502 Loyola Southway

c. Length of stay in Baltimore

40 Yrs.
Months
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Widow

8. DATE OF BIRTH

9. AGE (In years

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Earl

14. MOTHER'S MAIDEN NAME

Leslie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Earl W. Swartz - Same

18. 241X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Chronic Asthma

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Bronchitis

CERTIFICATION APPROVED BY

ONE OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/19/50 19, to 10/28/50 19, that I last saw the
deceased alive on 10/28/50 and that death occurred at 7:45 a. m., from the causes and on the date stated above.

23A. SIGNATURE

William Bangor M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

10/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 29 1950

Theobald Williams, Jr.

Jack Levine 2100 Eutaw Rd

112

MARGIN RESERVED FOR BINDING

PLEASE WRITE PRINTED, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
CENTERS FOR DISEASE CONTROL AND PREVENTION

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D-245
50 9253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9253

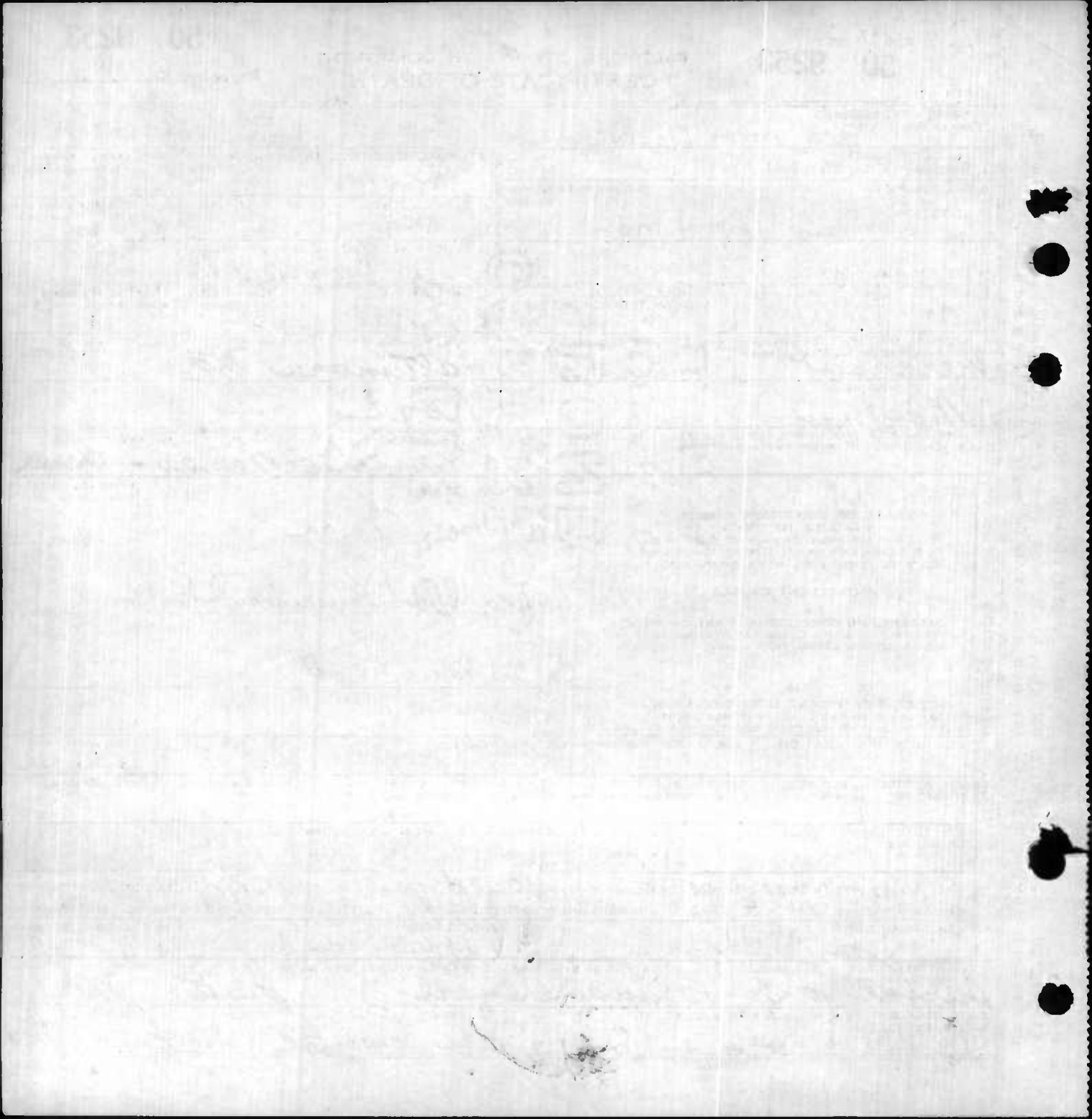
Registered No. _____

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <u>Benjamin Deckleman</u>			2. DATE OF DEATH <u>10-28-50</u>			
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>Baltimore</u>						
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Lutheran Hosp of Md</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTO Pikesville</u>						
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <u>6810 Comptfield Rd 5200</u>						
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Oct 1898</u>		9. AGE (In years last birthday) <u>52</u>		10 Under 1 Year Months: Days	11 Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>merchant</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Haberdashery</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>Morgan</u>			14. MOTHER'S MAIDEN NAME <u>Rose</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jennie Deckleman - Same</u>				ADDRESS

18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) <u>Pulmonary Edema</u>	DOE TO	
	(B) <u>Antero Septal Myocardial Infarction</u>	DUE TO	
	(C) <u>Cor. Art. Dis. & ACVD.</u>		

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-28, 6pm, 1950</u> to <u>10-28, 8pm, 1950</u> ; that I last saw the deceased alive on <u>10-28, 1950</u> , and that death occurred at <u>8p</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>John C. Lee</u>		23B. ADDRESS <u>Lutheran Hosp</u>		23C. DATE SIGNED <u>10-28-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-30-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Inaah Israel</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>		25. FUNERAL DIRECTOR <u>Jack Lewis Inc 2100 Eutaw Rd</u>			
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT 29 1950</u>		REGISTRAR'S SIGNATURE <u>Harry J. Williams</u>			

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



M-245
50 9254BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9254
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Elizabeth V. McWilliams</i>		2. DATE OF DEATH <i>10/27/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Harmon</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Baltimore McWilliams</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore Yrs. <i>0</i> Mos. <i>0</i> Days <i>0</i>		D. STREET ADDRESS (If rural, give location) <i>403 Warren Ave</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>N.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>	8. DATE OF BIRTH <i>5/28/1872</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Dress</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years - last birthday) <i>78</i>
13. FATHER'S NAME <i>Hugh McWilliams</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Elinor O'Keefe</i>	
17. INFORMANT <i>Miss Cath McWilliams</i>		ADDRESS	

18. E 903.0 <i>green (over)</i>		CAUSE OF DEATH <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 yrs</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		CERTIFICATION APPROVED BY <i>Stanley H. Durbacher</i> M. D. CHIEF OR ASST. MEDICAL EXAMINER.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO <i>Myocarditis</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO <i>Parkinson's disease</i>		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION <i>Fracture neck of femur</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>accident</i>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Fell in home</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>405W Warren Ave</i>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>?</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>Fell to floor</i>		
22. I hereby certify that I attended the deceased from <i>July 1</i> , 1950, to <i>October 27</i> , 1950, that I last saw the deceased alive on <i>Oct 25</i> , 1950, and that death occurred at <i>1230</i> p.m., from the causes and on the date stated above.				
23A. SIGNATURE <i>John W. Schenck</i>		23B. ADDRESS <i>1337 S. Charles St.</i>		23C. DATE SIGNED <i>10/27/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/30/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Lansdown Park</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 29 1950</i>		REGISTRAR'S SIGNATURE <i>William H. Williams</i>		25. FUNERAL DIRECTOR <i>J. J. Jones</i>
VS 150		ADDRESS <i>1318 Light</i>		

N 820.0

186a

Mr John Doyle: - please

give for date of accident
class

was accident contributing

or underlying cause of death ?

Z-565
50 9255BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9255

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) MARY ELLEN ZIMMERMAN		2. DATE OF DEATH OCT. 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION 00 22 WHEELER AVE.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE CITY 20-02	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 22 WHEELER AVE.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH APR. 9th, 1853
9. AGE (In years, last birthday) 97		10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) FREDERICK CO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM CLAY		14. MOTHER'S MAIDEN NAME CAROLINE KIEFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO *****		16. SOCIAL SECURITY NO. NO.	
17. INFORMANT WILLIAM R. ZIMMERMAN		ADDRESS SAME	

18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Myocardial Degeneration & insufficiency with congestive failure. Arteriosclerotic type heart disease. (B) generalized arterio sclerosis. (C) _____		INTERVAL BETWEEN ONSET AND DEATH General
---	--	--	--

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from September 1, 1950 to Oct 26, 1950 , that I last saw the deceased alive on Oct 26, 1950 and that death occurred at 9: P. M. , from the causes and on the date stated above.				
23A. SIGNATURE Dr. Michel		23B. ADDRESS M. O. 1015 Poplar Grove St		23C. DATE SIGNED Oct 28 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE OCT. 30, 1950	24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.	24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
DATE RECEIVED BY LOCAL REGISTRY OCT 29 1950	REGISTRAR'S SIGNATURE Thurston Williams, M.D.	25. FUNERAL DIRECTOR F.B. Wippert & Son		ADDRESS 093 d

VS 150

F.B. WIPPERT & SON 1300 EUTAW PL. 17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. Name of the person or persons to whom the certificate is issued

2. Date of birth

3. Place of birth

4. Sex

5. Race

6. Color

7. Height

8. Weight

9. Eyes

10. Hair

11. Complexion

12. Education

13. Occupation

14. Marital status

15. Date of marriage

16. Name of spouse

17. Name of children

18. Date of death

19. Cause of death

20. Place of death

21. Date of burial

22. Name of burial place

23. Name of funeral home

24. Name of minister

25. Name of officiating minister

26. Name of witnesses

27. Name of officiating minister

28. Name of witnesses

29. Name of officiating minister

30. Name of witnesses

31. Name of officiating minister

32. Name of witnesses

33. Name of officiating minister

34. Name of witnesses

35. Name of officiating minister

36. Name of witnesses

37. Name of officiating minister

38. Name of witnesses

39. Name of officiating minister

40. Name of witnesses

41. Name of officiating minister

42. Name of witnesses

43. Name of officiating minister

44. Name of witnesses

45. Name of officiating minister

46. Name of witnesses

47. Name of officiating minister

48. Name of witnesses

49. Name of officiating minister

50. Name of witnesses

51. Name of officiating minister

52. Name of witnesses

53. Name of officiating minister

54. Name of witnesses

55. Name of officiating minister

56. Name of witnesses

57. Name of officiating minister

58. Name of witnesses

59. Name of officiating minister

60. Name of witnesses

61. Name of officiating minister

62. Name of witnesses

63. Name of officiating minister

64. Name of witnesses

65. Name of officiating minister

66. Name of witnesses

67. Name of officiating minister

68. Name of witnesses

69. Name of officiating minister

70. Name of witnesses

71. Name of officiating minister

72. Name of witnesses

73. Name of officiating minister

74. Name of witnesses

75. Name of officiating minister

76. Name of witnesses

77. Name of officiating minister

78. Name of witnesses

79. Name of officiating minister

80. Name of witnesses

81. Name of officiating minister

82. Name of witnesses

83. Name of officiating minister

84. Name of witnesses

85. Name of officiating minister

86. Name of witnesses

87. Name of officiating minister

88. Name of witnesses

89. Name of officiating minister

90. Name of witnesses

91. Name of officiating minister

92. Name of witnesses

93. Name of officiating minister

94. Name of witnesses

95. Name of officiating minister

96. Name of witnesses

97. Name of officiating minister

98. Name of witnesses

99. Name of officiating minister

100. Name of witnesses

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9256
Registered No.

BIRTH NO.

50 9256

1. NAME OF DECEASED
(Type or Print)

Lillian M. (Coleman) GOHLINGHORST

2. DATE
OF
DEATH

Oct. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto..Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION Union Memorial Hospital

C. CITY OR TOWN

Baltimore

12-03

D. STREET ADDRESS (If rural, give location)

311 Whitridge

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 16, 1882

9. AGE (In years

last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James P. Coleman

14. MOTHER'S MAIDEN NAME

Emma Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Elsie M. Sidlowski 3900 Annapolis Rd.

18. 42010

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

B. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒ASSISTANT MEDICAL EXAMINER.....☐MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Oct. 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

A.A.Co. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

B. Fisher

25. FUNERAL DIRECTOR

ADDRESS

Flynn & Fleming 1426 Light St.

OCT 29 1950

093d

A-256
50 9257

CERTIFICATE CORRECTED 11-27-50

50 9257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. ASCHMEIER

2. DATE
OF
DEATH

Oct 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

Murray Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 23-03

c. Length of stay in Baltimore

life

D. STREET ADDRESS (If rural, give location)

11 W. North St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 8, 1898

9. AGE (In years last birthday)

52

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Builder on Ship

10B. KIND OF BUSINESS OR INDUSTRY

Ship worker

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Charles H. Aschmeier

14. MOTHER'S MAIDEN NAME

Julia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

work

16. SOCIAL SECURITY NO.

17. INFORMANT

Aschmeier

ADDRESS

Helmut Aschmeier, Baltimore Md

18.

442X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Renal failure, hypertension

(C) Atherosclerosis, Congestive Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

Actual onset

within

severe for past 3 wks

according to history

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ AT WHILE WORK ☒

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 25, 1950, to Oct 28, 1950, that I last saw the deceased alive on Oct 28, 1950, and that death occurred at 9:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Philip W. Neuman

23B. ADDRESS

Murray Hospital

23C. DATE SIGNED

Oct 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 31-1950

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Flynn & Fleming 1426 Light St.

OCT 29 1950

690 3U

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2/1/1915

MARGIN RESERVED FOR BINDING

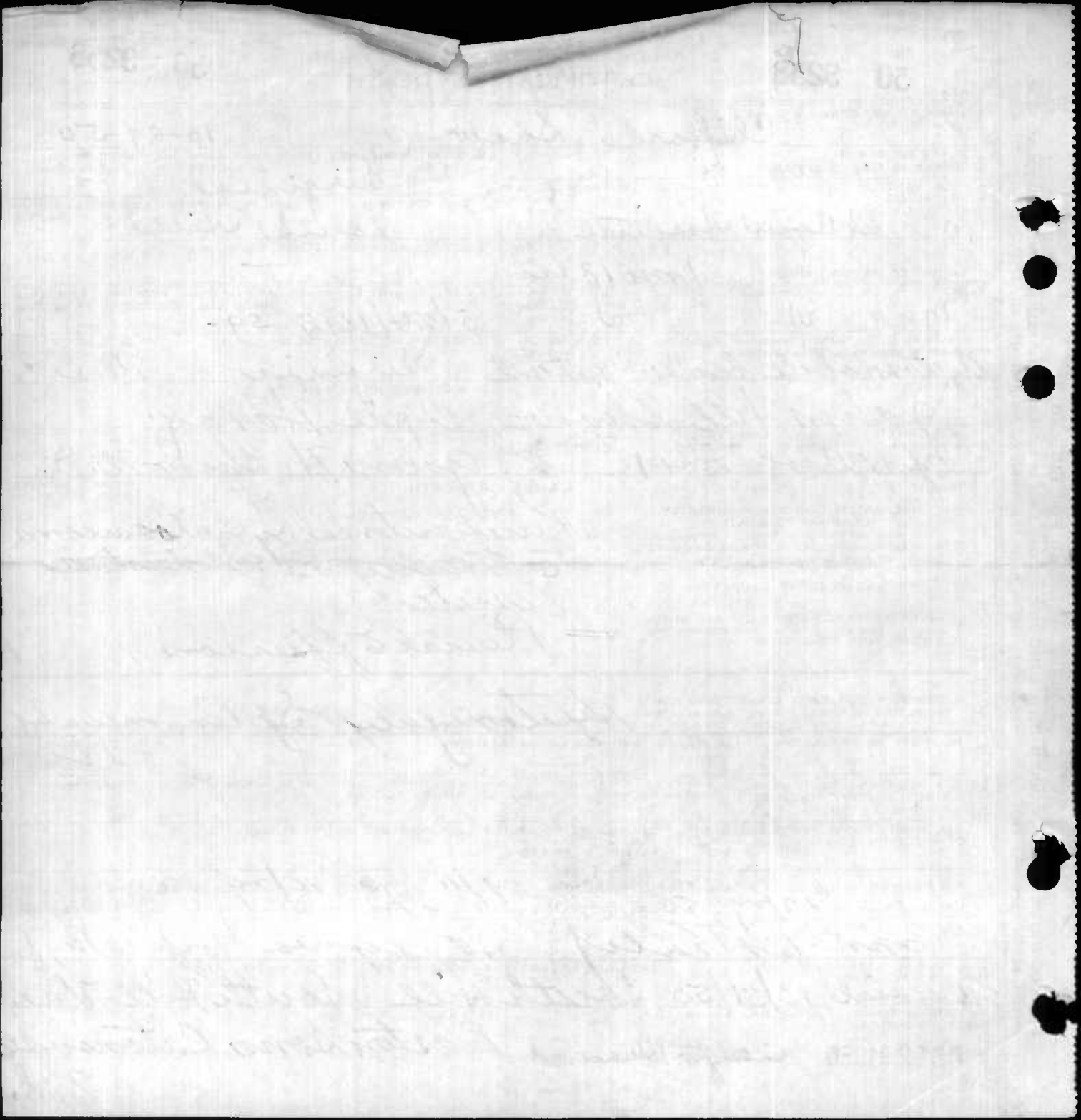
PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 50 9258	
BIRTH NO. 50 9258					
1. NAME OF DECEASED (Type or Print) <i>Clifford Shaw</i>				2. DATE OF DEATH <i>10-29-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Virginia</i> B. COUNTY <i>V-43</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>St Agnes Hospital</i>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>South Hill</i>	
C. Length of stay in Baltimore <i>1 mo 18 days</i>				D. STREET ADDRESS (If rural, give location) —	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i>	8. DATE OF BIRTH <i>5/24/1892</i>	9. AGE (in years last birthday) <i>58</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Automobile Dealer</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Retail</i>		
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Hill Shaw</i>			14. MOTHER'S MARDEN NAME <i>Opie Hardy</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes, 91st Airborne Div.</i>			16. SOCIAL SECURITY NO. <i>1-1-1-1-1-1-1-1-1-1</i>		
17. INFORMANT <i>John H. Shaw M.D.</i>			ADDRESS		
18. <i>200.1</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
(A) <i>Relioperitoneal Lymphosarcoma</i>					
(B) <i>Multiple Metastases</i>					
(C) <i>Aspirate</i>					
(D) <i>Flural Effusion</i>					
19A. DATE OF OPERATION <i>10/29/50</i>				19B. MAJOR FINDINGS OF OPERATION <i>Hepatomegaly & Splenomegaly</i>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9/11</i> , 19 <i>50</i> , to <i>10/29</i> , 19 <i>50</i> that I last saw the deceased alive on <i>10/29</i> , 19 <i>50</i> and that death occurred at <i>4:15</i> Am., from the causes and on the date stated above.					
23A. SIGNATURE <i>John H. Shaw</i>		23B. ADDRESS <i>St Agnes Hosp</i>		23C. DATE SIGNED <i>10/29/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/31/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>South Hill</i>	
24D. LOCATION (City, town, or county) (State) <i>South Hill Va.</i>		24E. FUNERAL DIRECTOR <i>Easton Sons</i>		24F. ADDRESS <i>Catonville</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 29 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. J. Williams</i>		25. FUNERAL DIRECTOR <i>Easton Sons</i>	
				ADDRESS <i>Catonville</i>	

OCT 29 1950

290 6J

0552 Md.



000 50 9259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9259

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Sister Mary Juliana Goetze			2. DATE OF DEATH 10/27/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 10-02		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Saint Joseph Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 901 Alisquith St.		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 12/8/65	9. AGE (In years last birthday) 84	10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Convent		
13. FATHER'S NAME Frank Goetze			14. MOTHER'S MAIDEN NAME Juliana Engelfinker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT S. Mary Koska			ADDRESS		

18. 570.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Indurinal obstruction DUE TO Cause undetermined	CAUSE OF DEATH (A) _____ (B) _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 16, 19 50 , to Oct. 27, 19 50 , that I last saw the deceased alive on Oct. 27, 19 50 , and that death occurred at 4:45 PM , from the causes and on the date stated above.					
23A. SIGNATURE Dr. J. J. Goetze		23B. ADDRESS St. Joseph's Hospital		23C. DATE SIGNED 12/27/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 01-30-50	24C. NAME OF CEMETERY OR CREMATORY Notch Cliff	24D. LOCATION (City, town, or county) (State) Glenview		
DATE RECEIVED BY LOCAL REGISTRAR OCT 30 1950		REGISTRAR'S SIGNATURE Dr. J. J. Goetze		25. FUNERAL DIRECTOR Rev. M. J. Smith	
ADDRESS		ADDRESS			

CASE 00

8522 00

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

WASH DC

APR 1900

NO

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

APR 1900

NO

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

WASH DC

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

APR 1900

NO

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

APR 1900

NO

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

APR 1900

NO

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

APR 1900

NO

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

APR 1900

NO

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

APR 1900

NO

RECEIVED BY THE SECRETARY OF THE

DEPARTMENT OF THE INTERIOR

H-520 50 9260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9260

BIRTH NO. 50-23102

1. NAME OF DECEASED
(Type or Print)

Garry -

Kines T. #1

2. DATE
OF
DEATH

Oct 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Hospital for the Women of Md

C. Length of stay in Baltimore

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

Maryland

B. COUNTY

14-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore-17

D. STREET ADDRESS (If rural, give location)

1519 Park Av.

5. SEX

Male

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct 26, 1950

9. AGE (In years,

last birthday)

10. Under 1 Year

Months Days

11. Under 24 Hours

Hours Min.

4 29

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S. A

13. FATHER'S NAME

Edward Ervin Kines

14. MOTHER'S MAIDEN NAME

Evelyn Steele

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

Edward E Kines

ADDRESS

1519 Park Av.

18. 776x

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Immediately

DUE TO

4 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Pneumonia

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-26-50, 1950, to 10-27-50, 1950, that I last saw the
deceased alive on 10-27, 1950, and that death occurred at 4:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Louis D. Rocca

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL OCT 27 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 30 1950

Huntley Williams

Commissioner of Health

ADDRESS

1590

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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THE NEW YORK PUBLIC LIBRARY

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50 9261

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

50 9261

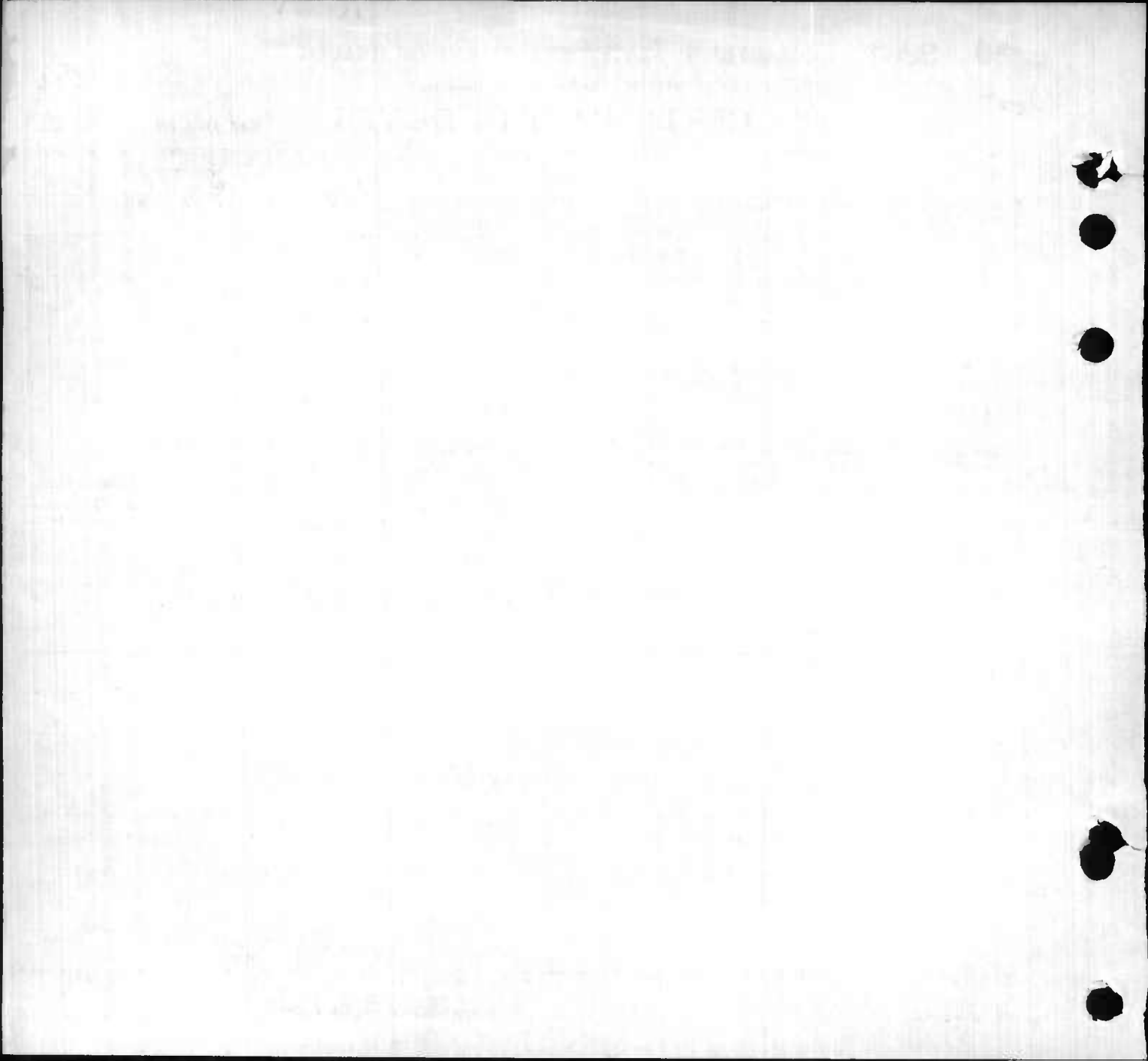
CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hood Convalescent Home</u>				STREET ADDRESS <u>128 S. Hilton St.</u> (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <u>Sarah</u>		(Middle)		(Last) <u>Musgrove</u>	
4. DATE OF DEATH		(Month) <u>Sept.</u>		(Day) <u>27</u>		(Year) <u>1950</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. (SINGLE) MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>?</u>	9. AGE last birthday <u>85</u> yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY No.		17. INFORMANT <u>Mrs. Sylvia Mock 128 S. Hilton St.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Congestive heart failure</u>							
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Malnutrition, severe</u>							
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				(STATE)			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 19</u> , 19 <u>50</u> , to <u>Sept 27</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Sept 27</u> , 19 <u>50</u> , and that death occurred at <u>7:00</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>Herbert J. Levickas, M.D.</u>				ADDRESS <u>5305 East Drive</u>		DATE SIGNED <u>Sept 28, 1950</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>		LOCATION (City, town, or county) (State) <u>OCT 3 1950</u>	
DATE REC'D BY LOCAL REG <u>OCT 30 1950</u>		REGISTRAR'S SIGNATURE <u>Walter William M.D.</u>		24. FUNERAL DIRECTOR <u>Commissioner of Health</u>		ADDRESS	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

093d



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9262
Registered No. _____

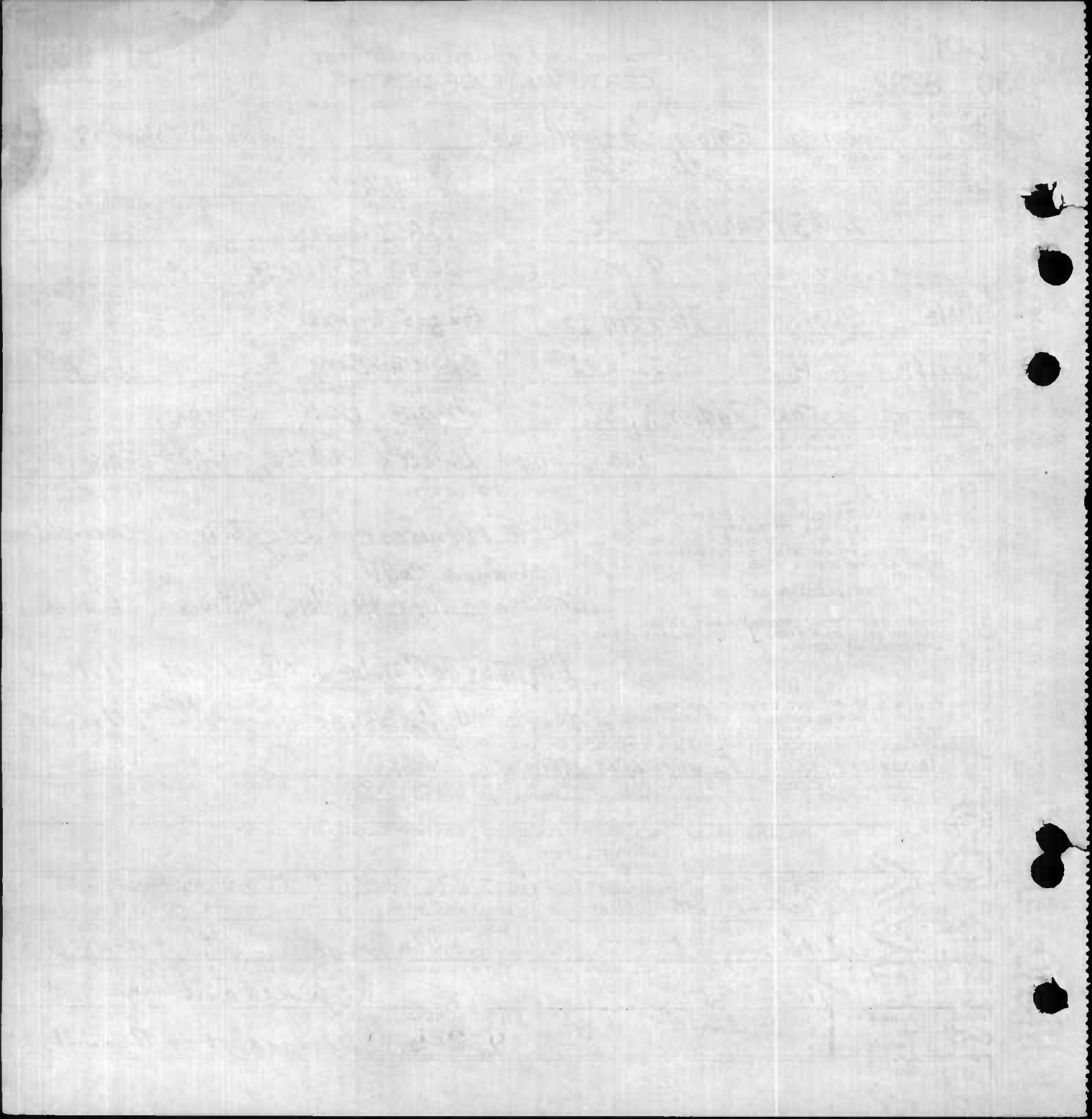
BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>George ESTON Bagwell, Jr.</u>			2. DATE OF DEATH <u>October 28, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto. City</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>2643 FRANCIS St.</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTIMORE</u>		
c. Length of stay in Baltimore <u>8 yrs.</u>			D. STREET ADDRESS (If rural, give location) <u>2643 FRANCIS St.</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>August 24, 1922</u>		9. AGE (In years last birthday) <u>28</u> H Under 1 Year Months: <u>2</u> Days: <u>4</u> H Under 24 Hours Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clauffeur - Butler</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	11. BIRTHPLACE (State or foreign country) <u>SPARTANBURG, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George ESTON Bagwell, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>ANNIE Bell GRANT</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>249-16-1199</u>	17. INFORMANT ADDRESS <u>Loretta White, 2643 FRANCIS St.</u>		

18. <u>160X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <u>ACUTE Pulmonary Congestion</u> DUE TO <u>(Squamous Cell)</u> (B) <u>CARCINOMA Left Maxillary Antrum</u> DUE TO _____ (C) <u>Metastases To Cerebrum; 7th Cervical Vertebra and Mediastinum (Hospital)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several Days</u> <u>Unknown</u> <u>Unknown</u>
19A. DATE OF OPERATION <u>JANUARY 4, 1950</u>		19B. MAJOR FINDINGS OF OPERATION <u>Tumor Left Maxillary Sinus</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Oct. 23, 1950</u> to <u>Oct. 28, 1950</u> , that I last saw the deceased alive on <u>Oct. 28, 1950</u> , and that death occurred at <u>10:20 A.M.</u> , from the causes and on the date stated above.						
23A. SIGNATURE <u>Richard H. Hunt</u>		23B. ADDRESS M. D. <u>1631 W. Franklin St.</u>		23C. DATE SIGNED <u>10-28-50</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-1-1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Spartanburg S. C.</u>		
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT 30 1950</u>		REGISTRAR'S SIGNATURE <u>Thurston H. ...</u>		25. FUNERAL DIRECTOR ADDRESS <u>Elroy Wilson 1000 Brantly on</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9263
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH ALLEN LEWIS

2. DATE
OF
DEATH

October 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Baltimore City Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7612 Cyprus Avenue

C. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

Oct. 6, 1897

9. AGE (In years last birthday)

53

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maintenance Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Glenn L. Martin Co

11. BIRTHPLACE (State or foreign country)

Hampton, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

J. Lewis

14. MOTHER'S MAIDEN NAME

Nannine Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Edith Lewis 7612 Cypress Ave.

18. E976X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of head and chest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH. BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

7612 Cyprus Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

October 26, 1950 4.00p.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self with rifle

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Ourlacher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Oct. 27, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county)

Colgate, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

W. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ulrich Funeral Home 2112 Dundalk Ave.

VS 151

N 878.4

2903T

164C

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

30 8523

STATE OF NEW YORK

30 8523

OFFICE OF THE ATTORNEY GENERAL

IN SENATE

January 1, 1900

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY:

WILLIAM H. BROWN, PRINTER

1900

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9264
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT Ford

2. DATE
OF
DEATH

October 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3208 Vickers Road

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 17, 1892

9. AGE (In years

last birthday)

58

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of

work done during most of working life, even if retired)

Makup Editor Sun Paper

10B. KIND OF BUSINESS OR

INDUSTRY

Co Newspaper Co.

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Harris Ford

14. MOTHER'S MAIDEN NAME

Jennie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

213-03-2675

17. INFORMANT

Mrs Mollie Ford

ADDRESS

3208 Vickers Road

18. 153X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Carcinoma of Colon

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

acute cardiac failure

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10/10/50

19B. MAJOR FINDINGS OF OPERATION

acute obstruction

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 7, 1950, to Oct. 29, 1950 that I last saw the deceased alive on Oct. 29, 1950, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Elmer B. Bergard

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

10/29/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

October 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Beth Tfiloh Cemetery

24D. LOCATION (City, town, or county)

Windsor Mill Road

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Sol Levinson + Bros W Northam

ADDRESS 1126

AB-142747

550

50 9265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9265

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Margaret Ann Inman (Inman)		2. DATE OF DEATH 10-28-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural) Middle River			
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 3 Middle River Ct. 5300			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan. 12-1950	9. AGE (In years last birthday) 9	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Robert Inman(Inman)		14. MOTHER'S MAIDEN NAME Dorothy Kerns	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Ave.	
18. 080.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Poliomyelitis Acute Paralytic Spinal DUE TO bulbar		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 10 Days (over)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-22- , 1950, to 10-28- , 1950, that I last saw the deceased alive on 10-28- , 1950, and that death occurred at 1.30P.m. , from the causes and on the date stated above.					
23A. SIGNATURE P. S. Rogers M. D.		23B. ADDRESS 4940 Eastern Ave.		23C. DATE SIGNED 10-28-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal-		24B. DATE Oct. 30-50		24C. NAME OF CEMETERY OR CREMATORY Carlisle Pk.	
24D. LOCATION (City, town, or county) (State) Baltimore		25. FUNERAL DIRECTOR ADDRESS Wm. Cook Inc. 1217 St Paul St			
DATE RECEIVED BY LOCAL REGISTRAR OCT 30 1950		REGISTRAR'S SIGNATURE Wm. Cook		25. FUNERAL DIRECTOR ADDRESS Wm. Cook Inc. 1217 St Paul St	

"Bulbar"

See Document File 50-9265

11-10-50

Es

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9266

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN Hooper SMITH

2. DATE
OF
DEATH

OCT 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MD.

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

UNIVERSITY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE - 10

D. STREET ADDRESS (If rural, give location)

Lombardy Apts. 40th & Stoney Run Lane

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

June 20, 1895

9. AGE (In years
last birthday)

55

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Electrical Engineer

10B. KIND OF BUSINESS OR
INDUSTRY

self CONST

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Harry Smith

14. MOTHER'S MAIDEN NAME

Mary J. Dick

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ethel Smith - 40th & Stoney Run Lane

18.

4201 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

MYOCARDIAL INFARCTION

18 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B) CORONARY THROMBOSIS

(C)

ARTERIOSCLEROTIC CARD. V.D.

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from OCT 14, 1950, to OCT 29, 1950, that I last saw the
deceased alive on OCT 29, 1950, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Edmund B. Middleton, M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

OCT. 29, 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Cremation

24B. DATE

10/30/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Crematory

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 30 1950

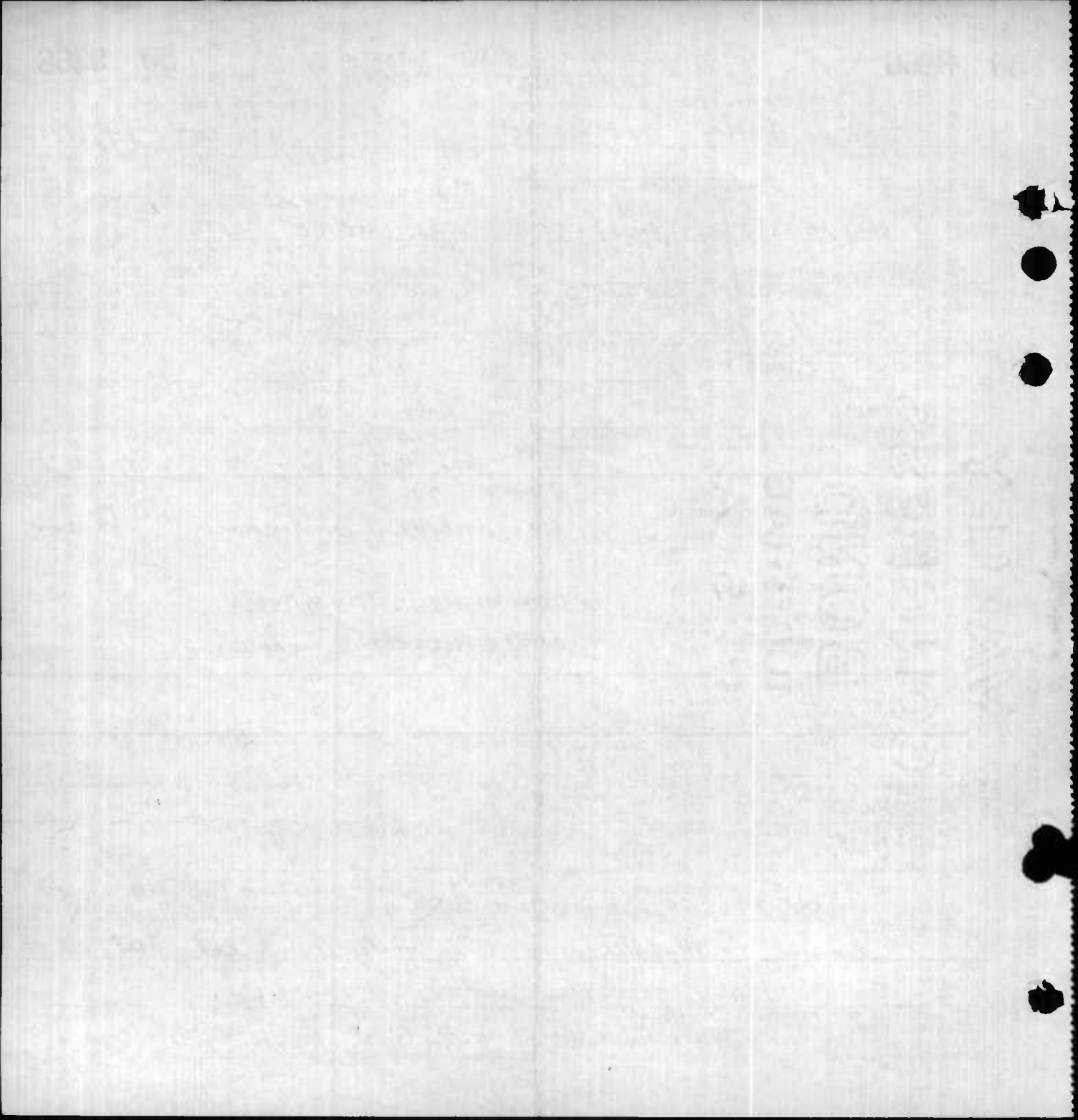
REGISTRAR'S SIGNATURE

Eustington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Pickens & Sons - Balto

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9267**W-363
50 9267
BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Wallis Woodward			2. DATE OF DEATH 10/27/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Balto		
a. FULL NAME OF (If not in hospital or institution, give street address or location) 2019 E 31st St			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto MD 9-06		
c. Length of stay in Baltimore Yrs. Mos. Days 2019 E 31st St			d. STREET ADDRESS (If rural, give location) 2019 E 31st St		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 22, 1870		9. AGE (In years last birthday) 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Food Canning	11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David A. Woodward			14. MOTHER'S MAIDEN NAME Josephine Laty		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT ADDRESS Mrs. Maude S. Woodward 2019 E. 31st. St.		

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ante-mortem C. U. Disease			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) DUE TO			(B) DUE TO		
19a. DATE OF OPERATION 0			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .								
23a. SIGNATURE P. Phelan			23b. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....			23c. DATE SIGNED 10/27/50		
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/30/50		24c. NAME OF CEMETERY OR CREMATORY Loudon Pk Cem.		24d. LOCATION (City, town, or county) (State) Balto. Md.		
DATE RECEIVED BY LOCAL REGISTRAR OCT 30 1950		REGISTRAR'S SIGNATURE Wm. J. T. Brown		25. FUNERAL DIRECTOR Wm. J. T. Brown		ADDRESS Son. Inc North Pa		

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9268

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FITZHUGH JAMES DODSON

2. DATE
OF
DEATH

10-27-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF
HOSPITAL OR
INSTITUTION

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
a. STATE b. COUNTY before admission)

MARYLAND

c. CITY OR TOWN

BALTIMORE

d. STREET ADDRESS (If rural, give location)

704 WYNDHURST AVE

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

12-9-1885

9. AGE (In years
last birthday)

64

10 Under 1 Year
Months: Days Hours: Min.10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

INVESTMENT BANKER

10b. KIND OF BUSINESS OR
INDUSTRY

INVESTMENT BANKING

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

ANDREW J. DODSON

14. MOTHER'S MAIDEN NAME

EMMA BARNES

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Mrs. Lillian N. Dodson 704 Wyndhurst Ave.

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

PNEUMONIA

DUE TO

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

CONGESTIVE HEART FAILURE 25 days

DUE TO

ARTERIO-SCLEROSIS

?

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21b. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-2, 1950, to 10-27, 1950, that I last saw the
deceased alive on 10-27, 1950, and that death occurred at 11:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE

Wallace J. Buttrick M. D.

23b. ADDRESS

Union Memorial Hospital 100 N. 1950

23c. DATE SIGNED

10-27-50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24b. DATE

10/31/50

24c. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24d. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. J. Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Jackson & Sons, Inc. North Co

ADDRESS

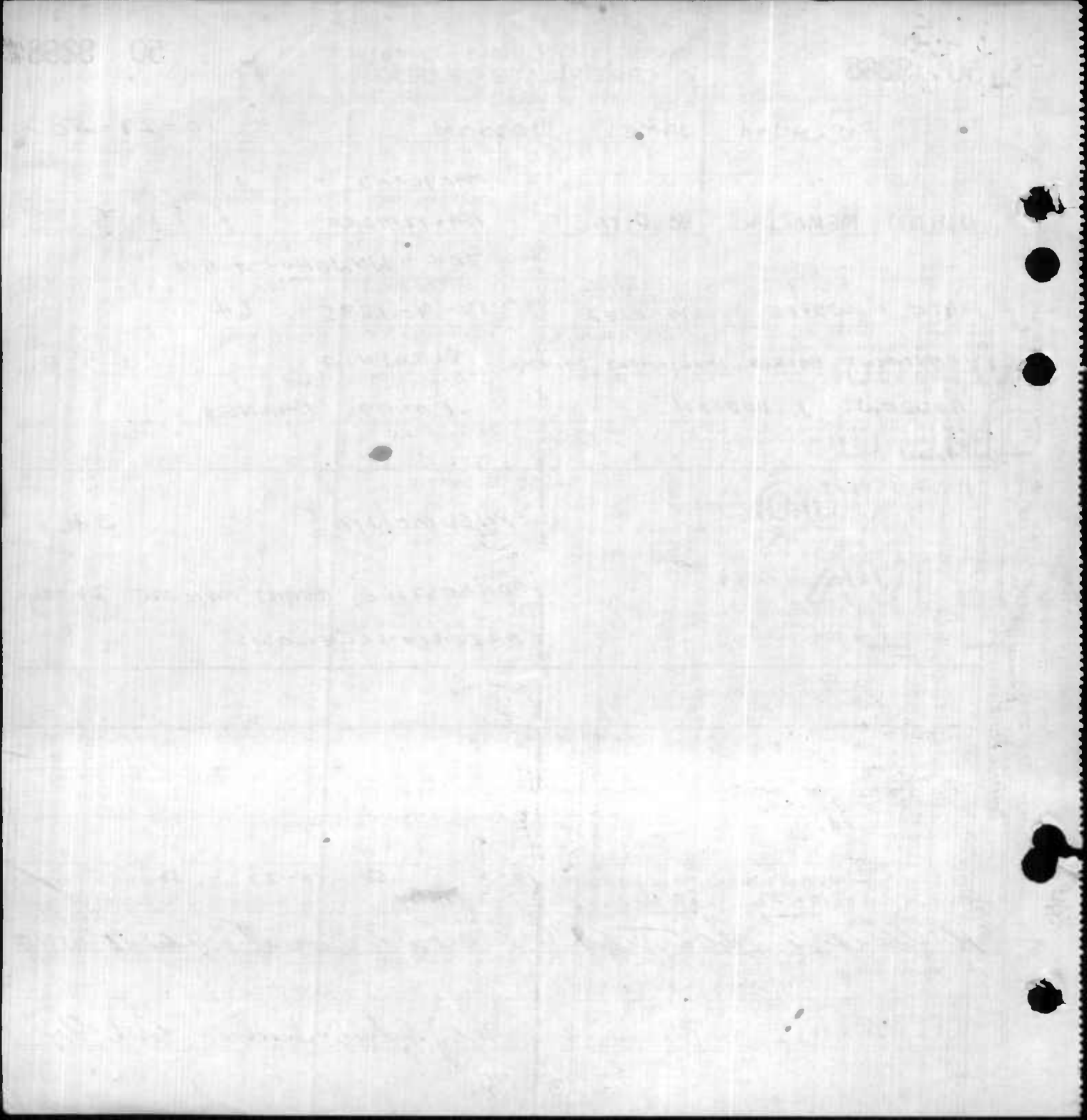
VS 150

290 72

0932

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN UNFADING INK. Every item of information should be carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



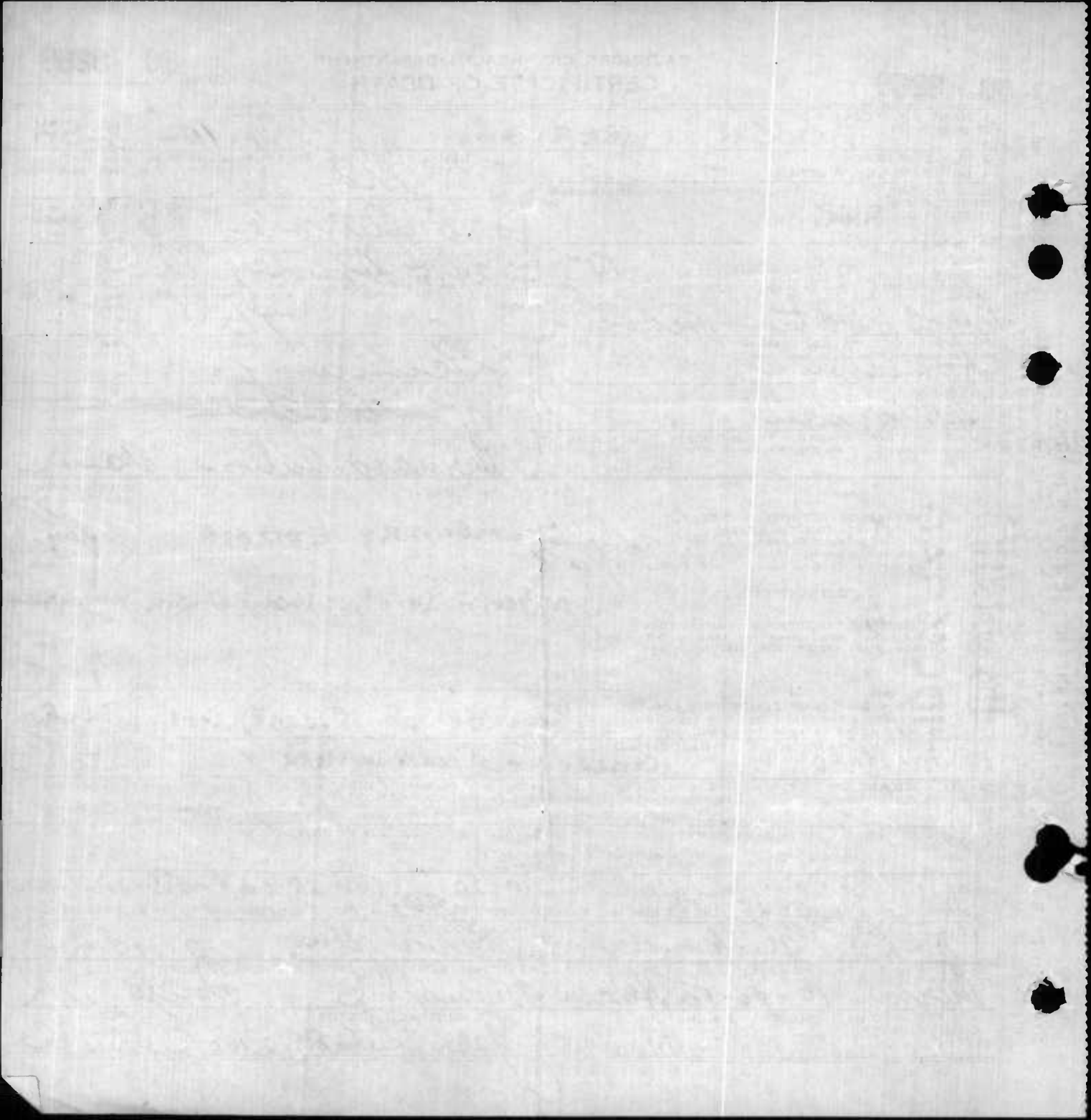
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9269

BIRTH NO. 50 9269

1. NAME OF DECEASED (Type or Print) ADLER, BERTHA		2. DATE OF DEATH 10-28-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Sinai		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-12	
c. Length of stay in Baltimore 15 Yrs. 5 Mos. 0 Ds.		D. STREET ADDRESS (If rural, give location) 2415 Shirley Ave	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 76
9. AGE (In years last birthday) 76		10. UNDER 1 Year Months: Days	11. UNDER 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Seligman		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Bernard Adler		ADDRESS Same	

18. 420.0 170X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) PULMONARY EDEMA		2 days	
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Arteriosclerotic Heart Disease		many years	
		DUE TO			
II		(C) Cancer of Breast, left		72 hrs	
19A. DATE OF OPERATION 10-25-50		19B. MAJOR FINDINGS OF OPERATION Cancer of Breast - left		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-20 19 50 , to 10-28 , 19 50 , that I last saw the deceased alive on 10-28 , 19 50 , and that death occurred at 3:30 p. m., from the causes and on the date stated above.					
23A. SIGNATURE B. J. Gluckman		23B. ADDRESS Sinai Hosp.		23C. DATE SIGNED 10-29-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 10-30-50		24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship	
24D. LOCATION (City, town, or county) Baltimore Md		24E. DATE RECEIVED BY LOCAL REGISTRAR OCT 30 1950		24F. REGISTRAR'S SIGNATURE William W. ...	
24G. DATE RECEIVED BY LOCAL REGISTRAR OCT 30 1950		24H. REGISTRAR'S SIGNATURE William W. ...		24I. FUNERAL DIRECTOR Jack Lewin	
24J. ADDRESS 2100 Eutaw Pl		24K. ADDRESS 2100 Eutaw Pl		24L. ADDRESS 2100 Eutaw Pl	



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9270

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY EISEN

2. DATE
OF
DEATH

10-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

2110 Westwood Ave

C. CITY OR TOWN

Baltimore 15-03

D. STREET ADDRESS (If rural, give location)

2110 Westwood Ave

c. Length of stay in Baltimore

24 Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (in years

last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

not known

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Abram Hadelman, 4009 Eldorado

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 30, 1950, to Oct 29, 1950, that I last saw the deceased alive on Oct 29, 1950, and that death occurred at 12 m., from the causes and on the date stated above.

23A. SIGNATURE

Edward J. Kallins

23B. ADDRESS

1847 W. North Ave

23C. DATE SIGNED

10/30/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-30-50

24C. NAME OF CEMETERY OR CREMATORY

Beth T. Filoh

24D. LOCATION (City, town, or county)

Balto, Md

DATE RECEIVED BY LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

Edward J. Kallins

25. FUNERAL DIRECTOR

Jack Lewis, 2100 Eutan Pl

VS 150

094a

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully and legibly. Physicians: please write the causes of death clearly and legibly.

Kalms
1847 W North 8-10
La 4871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9271

Registered No. _____

BIRTH NO. 50-24170

1. NAME OF DECEASED
(Type or Print)

Baby Boy Mislowski

2. DATE
OF
DEATH

Oct. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Mercy Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

6728 Boston ST.

c. Length of stay in Baltimore

LIFE 24 HRS

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Infant

8. DATE OF BIRTH

Oct. 28, 1950

9. AGE (In years last birthday)

H Under 1 Year Months: Days

H Under 24 Hours Hours: Min.

2 HRS

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md -

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William Mislowski

14. MOTHER'S MAIDEN NAME

ANN H. MALSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mother (above) SAME

18. 776x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) ...

DUE TO

Prematurity

INTERVAL BETWEEN ONSET AND DEATH

2 HRS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...

DUE TO

(C) ...

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 28, 1950, to Oct 28, 1950, that I last saw the deceased alive on Oct 28, 1950, and that death occurred at 4:36 Am., from the causes and on the date stated above.

23A. SIGNATURE

M. E. Matthews

M. D.

23B. ADDRESS

Mercy Hospital, Baltimore

23C. DATE SIGNED

Oct 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/30/50

24C. NAME OF CEMETERY OR CREMATORY

St. Andrew Russian

24D. LOCATION (City, town, or county)

Old German Rd. Balt.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

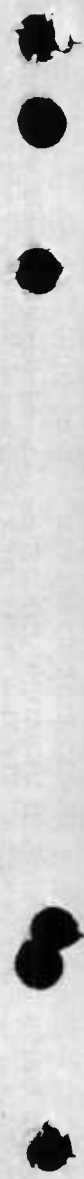
Walter Burke Bradley, Dundalk, Md.

ADDRESS

1936 08

RECEIVED
STATE OF CALIF.

1936 08



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 9272

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

WILLIAM C. Childs (Child)

2. DATE
OF
DEATH

Oct. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

4007 Edmondson Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

4007 Edmondson Ave

c. Length of stay in Baltimore

LIFE

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

JANUARY 31, 1895

9. AGE (In years
last birthday)

55

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Dispatcher

10B. KIND OF BUSINESS OR
INDUSTRY

Sun Cab Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SAMUEL J. Childs

14. MOTHER'S MAIDEN NAME

Lillian Looking Land

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

TELORES FLICKINGER 4007 Edmondson Ave

18. 153X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of thyroid

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

July/50

19A. DATE OF OPERATION

July 150

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of thyroid; obstructions

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐NOT WHILE ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 150, to Oct 27/50, 1950, that I last saw the
deceased alive on 12/25, 1950, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

22A. SIGNATURE

Samuel J. Wehner

M. D.

22B. ADDRESS

319 Md. Peds Bld. Bldg.

22C. DATE SIGNED

10/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10-30-50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

BALTIMORE, Md.

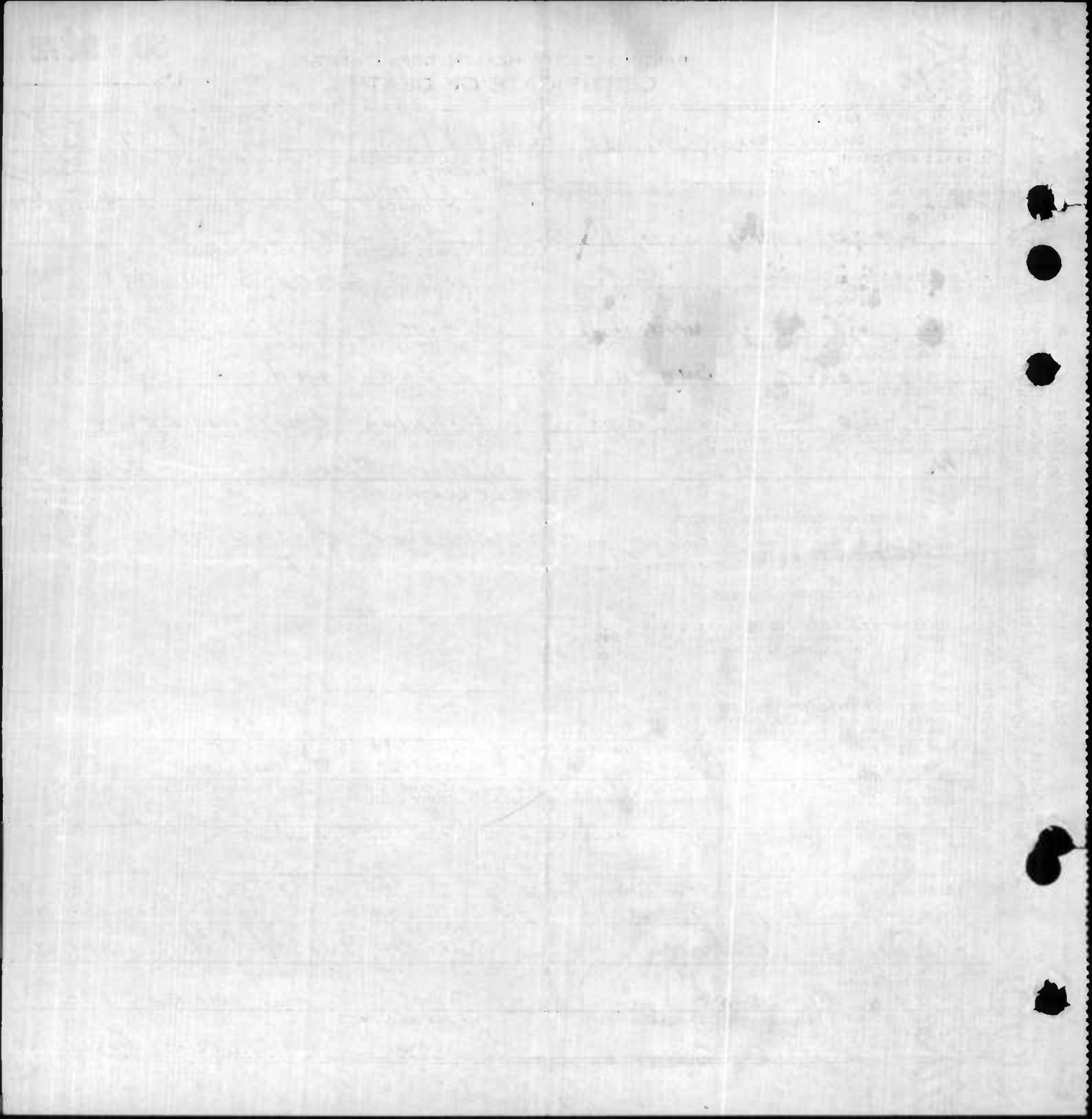
DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

GEORGE L. Schwab 2101 Frederick Ave.



MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death early and fully.

L-220
50 9273

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

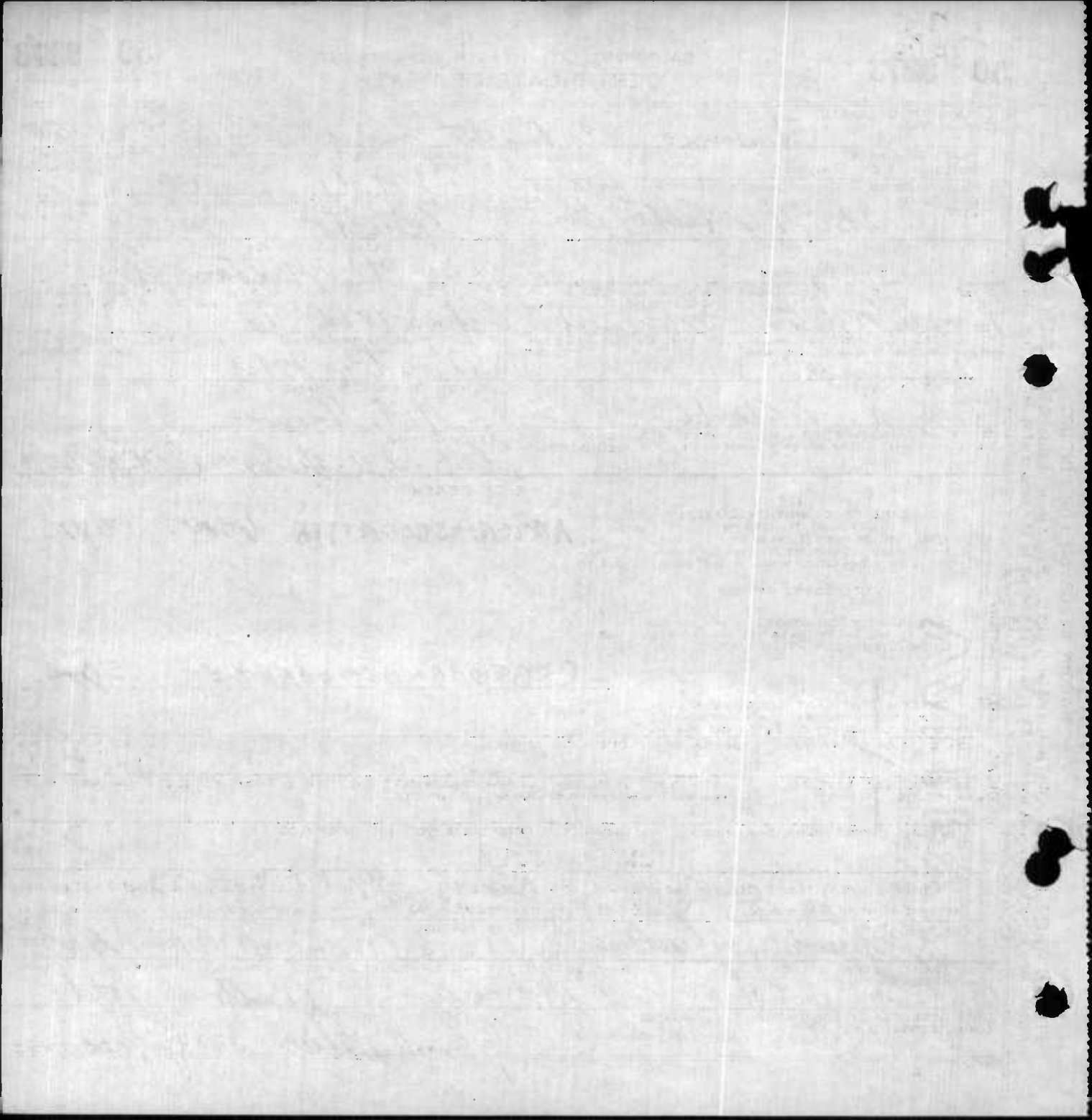
50 9273

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Frances Antonette Lukas</i>		2. DATE OF DEATH <i>Oct. 28-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>6-02</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>230 N. Milton Ave.</i>		C. CITY OR TOWN <i>Balto.</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>230 N. Milton Ave.</i>	
6. SEX <i>Female</i>	7. COLOR OR RACE <i>White</i>	8. DATE OF BIRTH <i>Oct. 23-1872</i>	9. AGE (In years, last birthday) <i>78</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Frank Chlada</i>		14. MOTHER'S MAIDEN NAME <i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Ambrose A. Lukas</i>		ADDRESS <i>230 N. Milton Ave.</i>	

18. <i>331X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>ARTERIOSCLEROSIS GEN.</i>		<i>3 YRS.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>CEREBRAL HEMORRHAGE</i>		<i>3 YRS.</i>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>AUG. 18, 1949</i> to <i>OCT. 28, 1950</i> that I last saw the deceased alive on <i>OCT. 28, 1950</i> and that death occurred at <i>2:05 P. M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Benjamin Hyatt</i>		23B. ADDRESS <i>1215 HIGHLAND AVE</i>		23C. DATE SIGNED <i>10-30-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>Oct. 31-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Red Hill Cem.</i>	
24D. LOCATION (City, town, or county) <i>Balto. Md.</i>		25. FUNERAL DIRECTOR <i>John H. Miller</i>		ADDRESS <i>2334 Jefferson</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 30 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		VS 150	

083a



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9274

BIRTH NO.		1. NAME OF DECEASED Marie Mary Spangler (Type or Print)		2. DATE OF DEATH Oct. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5300			
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 10 S. Hawthorne Street Middle River			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sept. 2, 1894	9. AGE (In years last birthday) 56 1/2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME August Rohde		14. MOTHER'S MAIDEN NAME Dena Hamer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Recrods B. C. H. 4940 Eastern Avenue	
18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH Unknown	
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-27 , 19 50 , to 10-27 , 19 50 , that I last saw the deceased alive on 10-27 , 19 50 , and that death occurred at 1:30P m., from the causes and on the date stated above.					
23A. SIGNATURE J. R. Davis M. D.		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 10-28-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/30/50		24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel	
24D. LOCATION (City, town, or county) (State) Baltimore		25. FUNERAL DIRECTOR Charles F. Hoffmann		ADDRESS 1639 Broadway	

VS 150 TO BE APPROVED BY MEDICAL EXAMINER

083 a

IN RE: [Illegible Name] [Illegible Address] [Illegible City, State, Zip]

Case No. [Illegible] Date of Filing [Illegible]

Plaintiff(s): [Illegible Name(s)]

Defendant(s): [Illegible Name(s)]

Allegation(s): [Illegible Text]

Relief Sought: [Illegible Text]

Signature of Plaintiff: [Illegible Signature]

Signature of Defendant: [Illegible Signature]

Witness Signature: [Illegible Signature]

Notary Public Signature: [Illegible Signature]

Notary Public Seal: [Illegible Seal]

Filed for Record: [Illegible Date]

By: [Illegible Name]

Attorney for Plaintiff: [Illegible Name]

Attorney for Defendant: [Illegible Name]

Witness: [Illegible Name]

Notary Public: [Illegible Name]

Signature of Plaintiff: [Illegible Signature]

Signature of Defendant: [Illegible Signature]

Witness Signature: [Illegible Signature]

Notary Public Signature: [Illegible Signature]

Notary Public Seal: [Illegible Seal]

Filed for Record: [Illegible Date]

By: [Illegible Name]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **50 9275**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Grace E. Helfrich

2. DATE
OF
DEATH **Oct. 29, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE
Md.

B. COUNTY
Baltimore

8. FULL NAME OF
HOSPITAL OR
INSTITUTION

3903 Greenmount Ave.,

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Preston R.F.D.#2 Box 30

D. STREET ADDRESS (If rural, give location)

E500

c. Length of stay in Baltimore

1-- Yrs.
Mes.
Days

5. SEX

Female

6. COLOR OR RACE
White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

6/28/1874

9. AGE (In years
last birthday)

76

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House-wife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Christopher Hamer

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Richard P. Helfrich, Preston, Md.

18. **442X**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) **Hypertension - Cardio-vascular
renal disease**

10 YRS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) _____
DUE TO _____

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) _____

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 2**, 1950, to **Oct. 29**, 1950, that I last saw the
deceased alive on **Oct. 28**, 1950, and that death occurred at **4:37 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

Lloyd C. Saylor M. O.

23B. ADDRESS

3902 Greenmount Ave.

23C. DATE SIGNED

Oct. 29, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11-2-1950

24C. NAME OF CEMETERY OR CREMATORY

Linchester

24D. LOCATION (City, town, or county)

Preston.

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

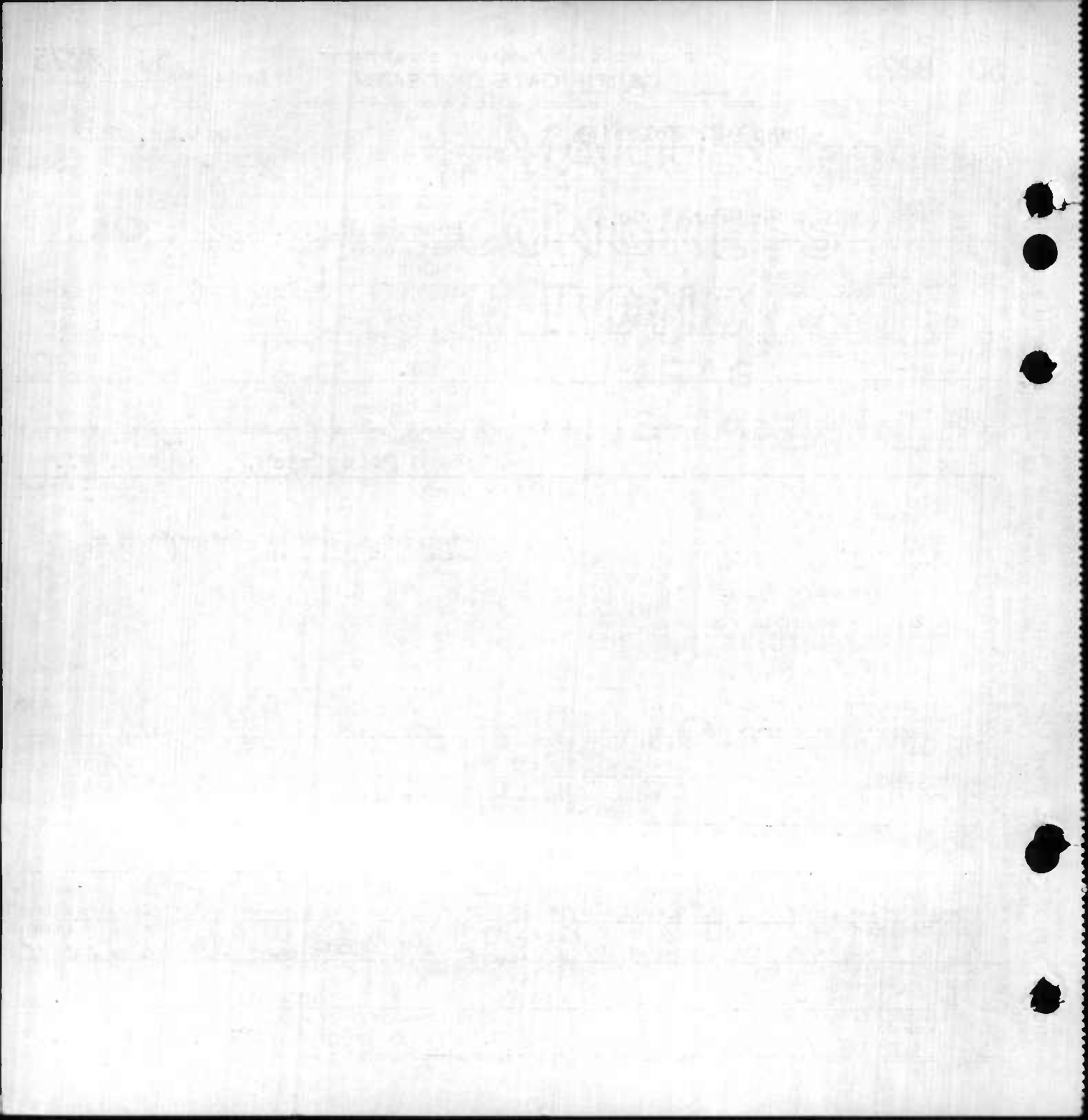
ADDRESS

G. Howard Strong 3207 W. North Ave.,

OCT 30 1950

VS 150

131a



432
50 9276BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9276
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Nelson Harrison Shields		2. DATE OF DEATH 10-27-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore 61 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2317 Ellamont St #16			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 6-23-1889	9. AGE (In years last birthday) 61	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bath overseer		10B. KIND OF BUSINESS OR INDUSTRY City employee		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Marshall W. Shields		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT wife ADDRESS Edith Brooks Shields as above	
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebrovascular accident		CAUSE OF DEATH (A) Cerebrovascular accident DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. cerebral arteriosclerosis		(B) cerebral arteriosclerosis DUE TO		unknown	
		(C) Hypertensive cardiovascular disease		unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Terminal bronchopneumonia					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-14, 1950 to 10-27, 1950 that I last saw the deceased alive on 10-27, 1950 and that death occurred at 3:45 m., from the causes and on the date stated above.					
23A. SIGNATURE Marguerite Louise Canfield, M.D.		23B. ADDRESS Maryland General Hosp		23C. DATE SIGNED 10-27-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-30-1950		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) Baltimore,		24E. STATE Md.			
DATE RECEIVED BY LOCAL REGISTRAR OCT 30 1950		REGISTRAR'S SIGNATURE Anthony J. Williams, M.D.		25. FUNERAL DIRECTOR G. Howard Strong	
				ADDRESS 3207 W. North Ave.,	

mo 7472

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9277
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles Edward Shaffer

2. DATE
OF
DEATH

Oct-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

2108-H Charles

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

at home

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Jan-30-1884

9. AGE (In years last birthday)

66

10. Under 1 Year Months Days

-

11. Under 24 Hours Hours Min.

-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bookkeeper

10B. KIND OF BUSINESS OR INDUSTRY

Brick (M)

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Martin L. Shaffer

14. MOTHER'S MAIDEN NAME

Katherine M. Becraft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Earl Levy

ADDRESS

805 Fidelity Bldg

18.

024X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Cerebral hemorrhage

DUE TO

Hypertension

(B) Arterio sclerosis, chronic nephritis

DUE TO

Tuberc, and two previous cerebral hemorrhages 1937

INTERVAL BETWEEN ONSET AND DEATH

3 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 20, 1937, to Oct-29, 1950, that I last saw the deceased alive on Oct-28, 1950, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John A. Lutscher

23B. ADDRESS

12 E Eager St

23C. DATE SIGNED

Oct 30 / 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/31/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Stewart Morrell, Balto.

ADDRESS

Balto.

VS 150

31037

030a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9278**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PANAGIS

ROSOLAMOS

2. DATE
OF
DEATH

Oct. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. ~~STATE~~ GreeceB. ~~PROVINCE~~ KessaloníaB. FULL NAME OF
HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

DEC 5, 1875

9. AGE (In years,
last birthday)

75

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

COCKS HELPER

10B. KIND OF BUSINESS OR
INDUSTRY

SEAMAN

11. BIRTHPLACE (State or foreign country)

GREECE

12. CITIZEN OF
WHAT COUNTRY?

GREECE

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....23C. DATE SIGNED
Oct. 30, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/31/50

24C. NAME OF CEMETERY OR CREMATORY

GREEK ORTHODOX CEM.

24D. LOCATION (City, town, or county)

BALTIMORE COUNTY MD.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Geo. S. Agnew FUNERAL HOME Inc

ADDRESS

118 W. Mt. Royal Ave

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3278

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8278

Dec 2, 1932

Female

Johnson

Cook's Helper

White male

White male

Creek Baltimore Co. Baltimore County Md.

Dec 2, 1932

Dec 2, 1932

10/2/32

10/2/32

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9279

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) WILLIAM B PHILLIPS		2. DATE OF DEATH Oct 29 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1501 Gorsuch Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 1501 Gorsuch Ave	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 17, 1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Store Self Seafood		10B. KIND OF BUSINESS OR INDUSTRY Seafood	
13. FATHER'S NAME Solomon Phillips		11. BIRTHPLACE (State or foreign country) Baltimore Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or oookooorv) _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. _____		14. MOTHER'S MAIDEN NAME _____	
17. INFORMANT Elizabeth Phillips (Wife)		ADDRESS _____	

18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Atherosclerosis, senile Sy.	CAUSE OF DEATH (A) _____ DUE TO _____ (B) _____ DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH _____
<p>II</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 1940 to 290-1 , 19 50 that I last saw the deceased alive on 270-1 , 19 50 , and that death occurred at 5 m., from the causes and on the date stated above.					
23A. SIGNATURE H. J. Condy		23B. ADDRESS 13 E. E. ...		23C. DATE SIGNED 290-1/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/31/50		24C. NAME OF CEMETERY OR CREMATORY Baltimore	
24D. LOCATION (City, town, or county) Baltimore Md		24E. DATE RECEIVED BY LOCAL REGISTRAR OCT 30 1950		24F. REGISTRAR'S SIGNATURE W. Williams	
24G. FUNERAL DIRECTOR J. M. Jenkins		24H. ADDRESS 2713 York Ave		24I. DATE 2906M	

CERTIFICATE OF DEATH

SAN FRANCISCO CITY HEALTH DEPARTMENT

Name of Deceased		Sex		Age		Date of Birth	
Place of Birth		Usual Residence		Occupation		Cause of Death	
Date of Death		Time of Death		Place of Death		Manner of Death	
Physician		Coroner		Burial Place		Burial Date	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness	

CAUSE OF DEATH

Immediate Cause		Intermediate Cause		Underlying Cause	
Contributing Cause		Manner of Death		Place of Death	
Date of Death		Time of Death		Place of Death	
Physician		Coroner		Burial Place	
Signature of Physician		Signature of Coroner		Signature of Registrar	

520
50 9281BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9281

Registered No. _____

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		LARVETT - GAINES		Oct. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
316 N. Mount St		Md.		Balt.	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)			
65		316 N. Mount St.			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months: Days
M	C	M	May 3-1877	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Porter		Ill. bar. Co. (M)	Essex Co. Va.		U. S.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Thomas Gaines					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
			Sarah Gaines - 316 N. Mount St.		
18. 332X		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral Thrombosis			3 weeks
ANTECEDENT CAUSES		(B) Hypertension			?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from Oct 7, 1950, to Oct 27, 1950, that I last saw the deceased alive on Oct 25, 1950, and that death occurred at 12 P. m., from the causes and on the date stated above.					
22A. SIGNATURE		23B. ADDRESS	23C. DATE SIGNED		
Douglas Shepperd		604 N. Fulton Ave	10/28/50		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
B		10-31-50	Arbutus	Balt.	Md.
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS		
OCT 30 1950		Wilmington Williams	Samuel W. Sullivan & Co		
VS 150		7803D 1011 N. Arbutus Ave 0836			

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9282

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LUCIUS READ WHITE, SR.

2. DATE
OF
DEATH

Oct. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

3501 Powhatan Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3501 Powhatan Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Dec. 31, 1863

9. AGE (In years,
last birthday)

86

If Under 1 Year
Months Days
If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Insurance

10B. KIND OF BUSINESS OR
INDUSTRY

Insurance

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Tyler White

14. MOTHER'S MAIDEN NAME

--

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

-

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Lucius R. White, Jr. 1009 N. Calvert St.

18. 443X.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Congestive Heart Failure

(B)

DUE TO

Myocarditis
Hypertension
Arterio-sclerosis

(C)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1926 to Oct 28, 1950 that I last saw the deceased alive on Oct 28, 1950 and that death occurred at 10 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/31/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

W. J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Williams & Sons - Balt.

1002

00

THE CITY OF NEW YORK

CERTIFICATE OF DEATH

1002

Blank certificate form with horizontal lines and a perforated edge on the right side.

CERTIFICATE CORRECTED

11-9-50 STRAUSS

A-80727

50 9283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>George L. Strauss</i>		2. DATE OF DEATH <i>Oct. 28, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Balto. Gen. Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>2789 The Alameda</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>July June 19, 1885</i>	9. AGE (in years last birthday) <i>65</i>	If Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Toolmaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Airplane Mfr.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Adolph Strauss</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Durrabeck</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Mary C. Strauss 2789 The Alameda</i>	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Coronary Artery Arterio-sclerosis</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>		

19A. DATE OF OPERATION <i>Oct 28</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Oct 22</i> , 1950, to <i>Oct 28</i> , 1950, that I last saw the deceased alive on <i>Oct 28</i> , 1950, and that death occurred at <i>11:55 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Colleen</i>		23B. ADDRESS <i>South Balto. Gen. Hospital</i>		23C. DATE SIGNED <i>Oct 28/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE OF BURIAL <i>10/31/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	
24D. LOCATION (City, town, or county) <i>Balto., Md.</i>		25. FUNERAL DIRECTOR <i>Wm. J. Vickers & Sons - Balto Md.</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 30 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		ADDRESS	

VS 150

592 3T

061.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2830

DE

2830

OL

50

9284

M-261

M^{rs} GreevyBALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9284

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Philip F. McGreevy

2. DATE
OF
DEATH

Oct. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1000 Caton Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
1000 Caton Ave., Balto. Md.B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Jenkin's Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write FULL and give township)

Baltimore, Md.

D. STREET ADDRESS (If rural, give location)

1000 - Caton Ave.

C. Length of stay in Baltimore

63 yrs.

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

1-29-76

9. AGE (In years
last birthday)

74 yrs.

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

LAWYER.

10B. KIND OF BUSINESS OR
INDUSTRYSTATE ACCIDENT -
Company

11. BIRTHPLACE (State or foreign country)

COANSAY
- Worsley, England.12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Patrick McGreevy

14. MOTHER'S MAIDEN NAME

Bridget MURPHY.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. MARY-KNIGHTON - 4902 Stafford St.
Mrs. Mary McKnighton

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) ARTERIOSCLEROTIC CARDIO -
DUE TO VASCULAR DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) CACHEXIA
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1950 to 10/28, 1950 that I last saw the
deceased alive on 10/25, 1950, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial.

Oct. 31, 1950

New Cathedral Cemetery.

Baltimore - Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 30 1950

Huntington Williams, M.D.

Charles J. Schwab, 3512 Fredk. Ave.

1000-00

RECEIVED - JUNE 10 1964
UNITED STATES DEPARTMENT OF JUSTICE

100



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9285

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

(Lillian) LILY MAE TEETERS

2. DATE
OF
DEATH

Oct. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1001 W. Baltimore St.

C. CITY OR TOWN (If outside corporate limits, write FULL and give township)

Baltimore

c. Length of stay in Baltimore

9

D. STREET ADDRESS (If rural, give location)

1001 W. Baltimore St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 4, 1888

9. AGE (in years last birthday)

62 yrs

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Zadoc Griffith

14. MOTHER'S MAIDEN NAME

Mary Catherine Conklin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS Trenton

Mrs. Ruby Barlow, 1000 Melrose Ave., N.J.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. S. Fisher

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐ M.D. MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED Oct. 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

Walter J. Williams, M.D.

25. FUNERAL DIRECTOR

E. Willis Lamoreau ADDRESS 1003 W. Baltimore St.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9286
S-220

50 9286

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Willie A. Sykes

2. DATE
OF
DEATH October 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

1406 W. Cold Spring Lane

D. STREET ADDRESS (If rural, give location)

1406 W. Cold Spring Lane

c. Length of stay in Baltimore

65 years

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 7, 1877

9. AGE (in years
last birthday)

72

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Sample man

10B. KIND OF BUSINESS OR
INDUSTRY

Cotton Mill

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U S A

13. FATHER'S NAME

Wesley Sykes

14. MOTHER'S MAIDEN NAME

Georgeann Hager

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-03-4331

17. INFORMANT

ADDRESS Lane

Mrs. Ellen Viola Sykes 1406 W. Cold Spring

18. 151X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

2-8-50

Carcinoma of stomach
& generalized carcinomatous

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-8-1950 to 10-28, 1950 that I last saw the
deceased alive on 10-27, 1950 and that death occurred at 10:50 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Lemmon H. Lemmon

M. O.

23B. ADDRESS

3711 Fall Rd

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 31, 1950

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Baltimore Co., Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Lemmon H. Lemmon

25. FUNERAL DIRECTOR

ADDRESS

Burgee Funeral Home 3631 Falls Road

OCT 30 1950

684 4E Horace F. Burgee 0461

October 1, 1950

Mr. J. Edgar Hoover

Director

Mr. W. C. Sullivan

Mr. E. A. Tamm

Mr. J. B. Connelley

75

Mr. J. L. ...

Mr. J. B. ...

Mr. J. B. ...

Mr. J. L. ...

Mr. J. B. ...

Mr. J. B. ...

Mr. J. L. ...

Mr. J. B. ...

Mr. J. B. ...

Mr. J. L. ...

Mr. J. L. ...

Mr. J. L. ...

Mr. J. L. ...

Mr. J. L. ...

Mr. J. L. ...

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9287

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Thomas S. Hauck

2. DATE
OF
DEATH

Oct. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

27-12

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

5100 N. Charles St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug 12, 1887

9. AGE (in years
last birthday)

63

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR
INDUSTRY

Plywood Bus

11. BIRTHPLACE (State of foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George F. M. Hauck

14. MOTHER'S MAIDEN NAME

Clara Biehl

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes War I + II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ella Davis Hauck, 5100 N. Charles St.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardio-
vascular DiseaseOTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT

(C)

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

Oct. 28, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10/30/50

Oct. 31/50

Heenmount

Baltimore

10/30/50

William H. Kammer, Jr.

Loring Byers

505 Pk. Hyattsville

1930

06

1930

06

1930

06

1930

06

1930

06

1930

06

1930

06

W-420

50 9288

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50 9288

CERTIFICATE OF DEATH 420.1

Reg. Dist. No.

1. PLACE OF DEATH:

County.....
City or town BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? APPROXIMATELY SEVEN MONTHS
Hospital, institution, or street address where death occurred:
EDGEWOOD NURSING HOME - 6000 BELLEUNA AVE.
How long in hospital or institution? APPROXIMATELY SEVEN MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County KENT
City or town CHESTERTOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No. 616 W. HIGH ST.
(If rural, give LOCATION) 6431
2.(a) If veteran, name war

3. (a) FULL NAME

MIRIAM HELEN WILLIS

3. (b) Social Security Number

215-20-1543

4. Sex F 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED
6.(b) Name of husband or wife THOMAS WILLIS
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-4-1880
8. AGE: Years 70 Months 1 Days 25 If less than one day hrs. min.

9. Birthplace KENT COUNTY
(Town, county, and state)
10. Usual occupation HOUSEWIFE

11. Industry or business
FATHER 12. Name JOHN C. LECOMPT
13. Birthplace KENT COUNTY (MARYLAND)
MOTHER 14. Maiden name MELVINA READ
15. Birthplace KENT COUNTY, MARYLAND

16. Informant EARL T. WILLIS
Address 11 CEDAR AVE, TOWSON, MD.
17. BURIAL Date thereof 11-1-50
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory CHESTER
Location CHESTERTOWN, MARYLAND

18. Funeral director MARYN WILLIAMS
Address CHESTERTOWN, MARYLAND

19. 30 19 50
(Date rec'd by registrar) Registrar Wm. H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 19 50 at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 50 to Oct 26 19 50
and that I last saw him alive on Oct 26 19 50

Immediate cause of death DURATION
Coronary Occlusion - Sudden
Due to Arteriosclerosis sub.
+ Hypertension
Due to
Other conditions

(Include pregnancy within 8 months of death)
Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? 094a

23. SIGNATURE John H. Leight W.D.
Address Towson - 4 - W.D. Date signed Oct 30, 50

2292

10

STATE OF NEW YORK

IN SENATE

2292

10

RECEIVED

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-543
50 9289

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9289
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. Katie Cecilia Samilton		2. DATE OF DEATH Oct. 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-01			
c. Length of stay in Baltimore 61yr.		D. STREET ADDRESS (If rural, give location) 736 Light Street			
5. SEX Fe.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 9, 1886	9. AGE (In years last birthday) 64yrs	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwfe.		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Lawrence Anarino		14. MOTHER'S MAIDEN NAME Rosie Gentile	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Wm. H. Samilton 736 Light St.	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Pulmonary embolism ANTECEDENT CAUSES (B) acidosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) Diabetes mellitus II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH (over)	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/26/1950, to 10/28/1950, that I last saw the deceased alive on 10/28/1950, and that death occurred at 3:20AM, from the causes and on the date stated above.					
23A. SIGNATURE Madclaus Swinski		23B. ADDRESS M. D. 1400 N. Caroline Street		23C. DATE SIGNED 10/28/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 31, 1950		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Highway Balto. Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE Washington Williams, M.D.	
24G. FUNERAL DIRECTOR KRAUSE FUNERAL HOME 1216 S. Charles St		24H. ADDRESS		24I. Balto. 30 Md.	

OCT 30 1950
VS 150

061.0

Query

I wish to determine a probable
sequence of events which led from
underlying cause to the terminal
pulmonary embolism — may we ask
if diabetes was the underlying cause?
with thrombophlebitis? to pulmonary embolism?
or? — Diabetes contributing with
underlying cause of pulmonary embolism?

See Document File 50-9289

11-14-50

ES

HICKMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

 50 9290
 Registered No.

BIRTH NO. 48-24810

 1. NAME OF DECEASED
 (Type or Print)

Clarence Hickman

 2. DATE
 OF
 DEATH

10-28-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

 B. FULL NAME OF (If not in hospital or institution, give street address or location)
 HOSPITAL OR INSTITUTE

Univ. Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt.

14-00

D. STREET ADDRESS (If rural, give location)

1517 S. Cullough St

c. Length of stay in Baltimore

 Yrs.
 Mos.
 Days

5. SEX

M

6. COLOR OR RACE

B

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/25/48

9. AGE (In years last birthday)

2

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George C. Hickman

14. MOTHER'S MAIDEN NAME

Ethel Kane Hickman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

George C. Hickman

 ADDRESS
 1517 S. Cullough St

18. 757.3

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Bilat Hydronephrosis & Hydroureter

Cong. anomaly

INTERVAL BETWEEN ONSET AND DEATH

 10-28-50
 10-30-50

9-29-50

 II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

 YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

William S. Baumann

M. D.

23B. ADDRESS

Univ. Hosp.

23C. DATE SIGNED

10-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

10/31/50

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county)

Balto. Co., Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Livingston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Charles R. Law - 802 Mad. Ave.

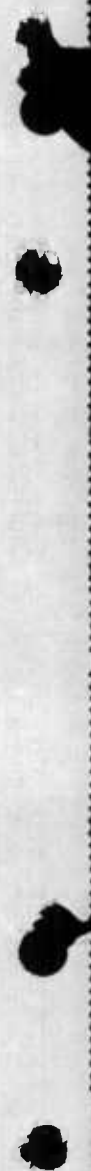
OCT 30 1950

VS 150

157 h

W. W. WATKINS
J. J. WATKINS
J. J. WATKINS

W. W. WATKINS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9291**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BEATRICE DOSWELL

2. DATE OF DEATH

October 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, write R. R. and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1527 N. Monroe Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 4, 1925

9. AGE (In years last birthday)

24

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Meherrin, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Herbert Doswell

14. MOTHER'S MAIDEN NAME

Helen Windbush

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

240-38-8888

17. INFORMANT

ADDRESS

Helen W. Doswell - Meherrin, Va

18. **650.0**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **External hemorrhage**

DUE TO **Incomplete abortion**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Stanley B. Dunsen

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Oct. 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Zion Cemetery Meherrin, Va.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Charles R. Law - 802 Mad. Ave.

1088

1088



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9292
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND BARKLEY

2. DATE
OF
DEATH

Oct. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Balto. City**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

D. STREET ADDRESS (If rural, give location)

1836 Prestman Street

B. FULL NAME OF (If not in hospital or institution, give street address or location)

PROVIDENT

C. Length of stay in Baltimore

10 Yrs.

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

10/19/1889

9. AGE (In years last birthday)

61

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Dames Quater Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Barkley

14. MOTHER'S MAIDEN NAME

Julia Barkley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Rosa Irene Halcum 1822 Walbrook Ave

18. **420.1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary artery sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inspection & Inquiry** thereon and from the evidence obtained by said **Autopsy, Inspection or Inquiry**, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Durschner

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

Oct. 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

II/I/1950

24C. NAME OF CEMETERY OR CREMATORY

Dames Quater Cem.

24D. LOCATION (City, town, or county)

Dames Quater Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams

25. FUNERAL DIRECTOR

ADDRESS

Elroy Wilson 1001 Brantley

OCT 30 1950

V S 151

97024

094a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED

11-2-50

BALTIMORE CITY HEALTH DEPARTMENT

50 9293

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

C. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

5. SEX

6. COLOR OF RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A)

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1947, to Oct 28, 1950, that I last saw the
deceased alive on Oct 27, 1950, and that death occurred at m., from the causes and on the date stated above.

22A. SIGNATURE

22B. ADDRESS

22C. DATE SIGNED

23A. BURIAL, CREMA-
TION, REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION (City, town, or county)

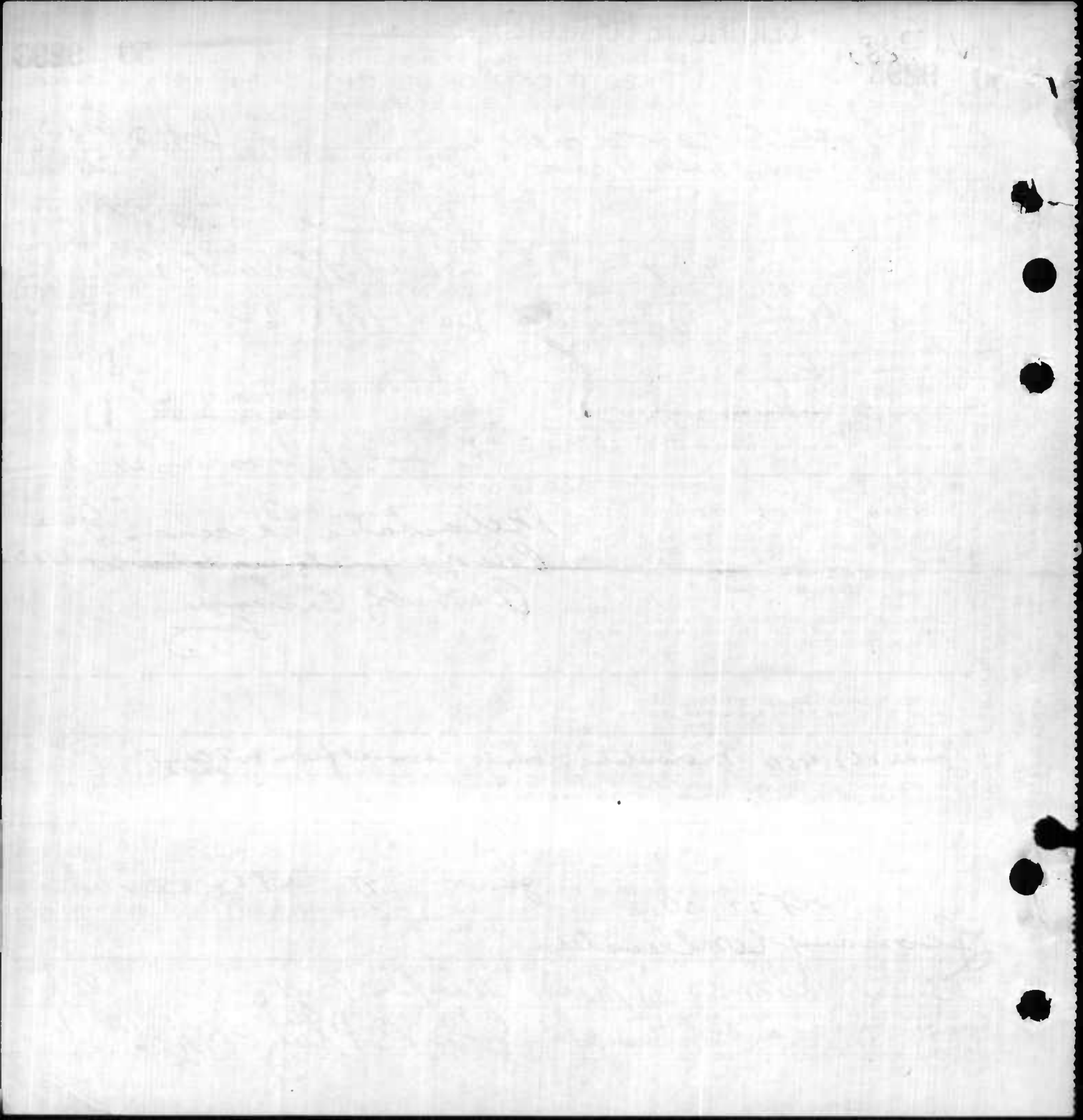
(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9294

BIRTH NO. 400 9294

1. NAME OF DECEASED
(Type or Print)

Charles F. Kiel, Sr.

2. DATE
OF
DEATH

Oct. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital (DOH)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (if rural, give location)

3806 Colborne Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

June 8, 1894

9. AGE (in years
last birthday)

56

H Under 1 Year
Months: DaysH Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Attendant

10B. KIND OF BUSINESS OR
INDUSTRY

Gasoline Station

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles F. Kiel, Sr.

14. MOTHER'S MAIDEN NAME

- Brainard

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Anna A. Kiel - 3806 Colborne Rd.

18. E974X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Strangulation - by Hanging

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Despondency

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)
Home21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)
Basement - 3806 Colborne Road21D. TIME (Month) (Day) (Year) (Hour)
of INJURY
October 29, 1950 4:26P.21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☒21F. HOW DID INJURY OCCUR?
Hanged himself in basement by a rope
suspended from the rafters22. I certify that I took charge of the remains described above, held an Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct. 30, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/31/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 30 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Pickens & Sons - Balto

ADDRESS

164a

VS 151

N-991X

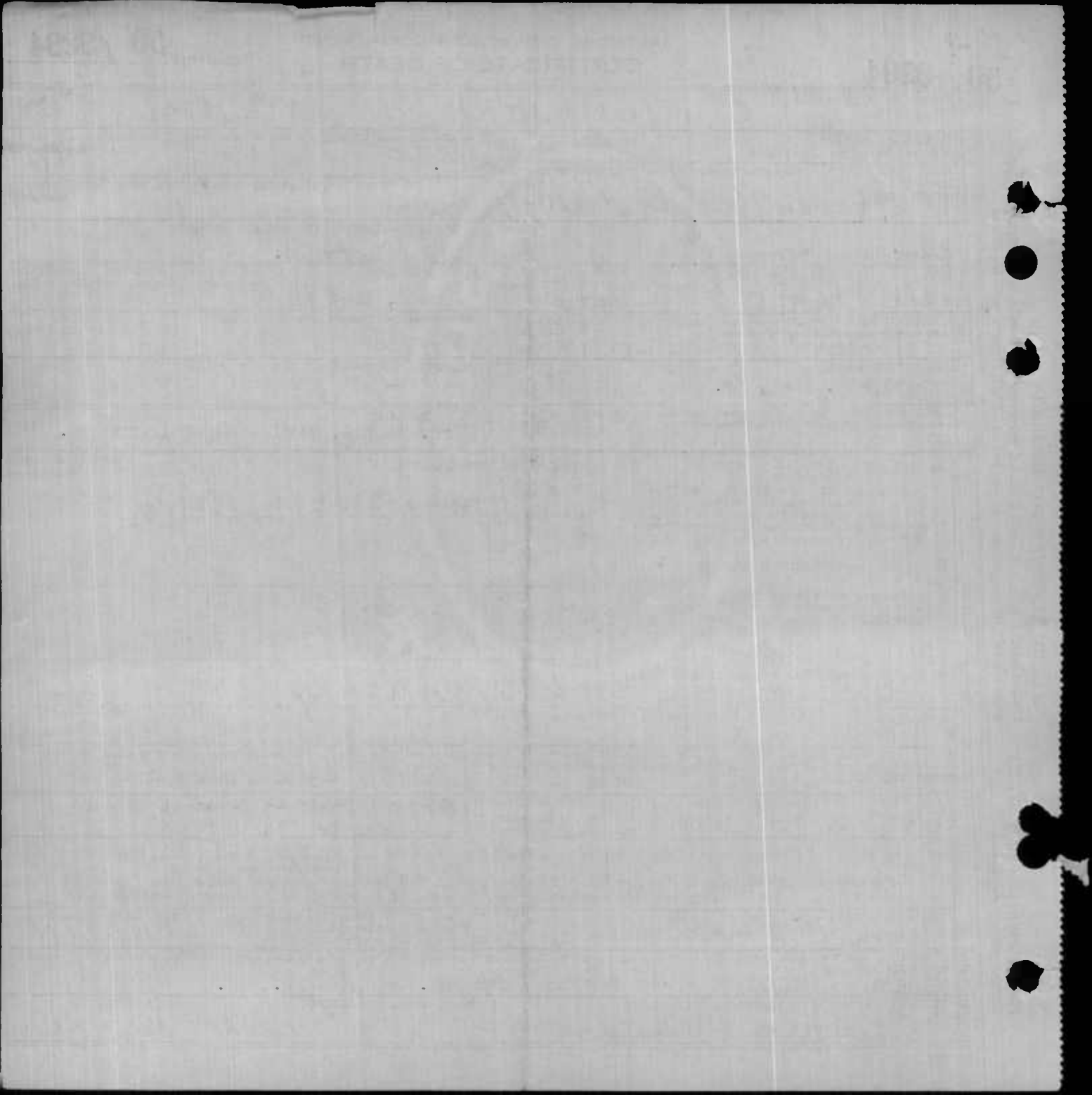
621 6K

164a

md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 9295

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Franklin Webb			2. DATE OF DEATH 10/28/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 701 Belgian Ave.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-20-98		9. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator			10B. KIND OF BUSINESS OR INDUSTRY Street Railway		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John W. Webb			14. MOTHER'S MAIDEN NAME Blanche M. Bateman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes			16. SOCIAL SECURITY NO. 213-10-0851		
17. INFORMANT Helen M. Webb			ADDRESS 701 Belgian Ave.		

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis	CAUSE OF DEATH (A) Coronary thrombosis DUE TO coronary artery arteriosclerosis (B) _____ DUE TO _____ (C) Hypertension	INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

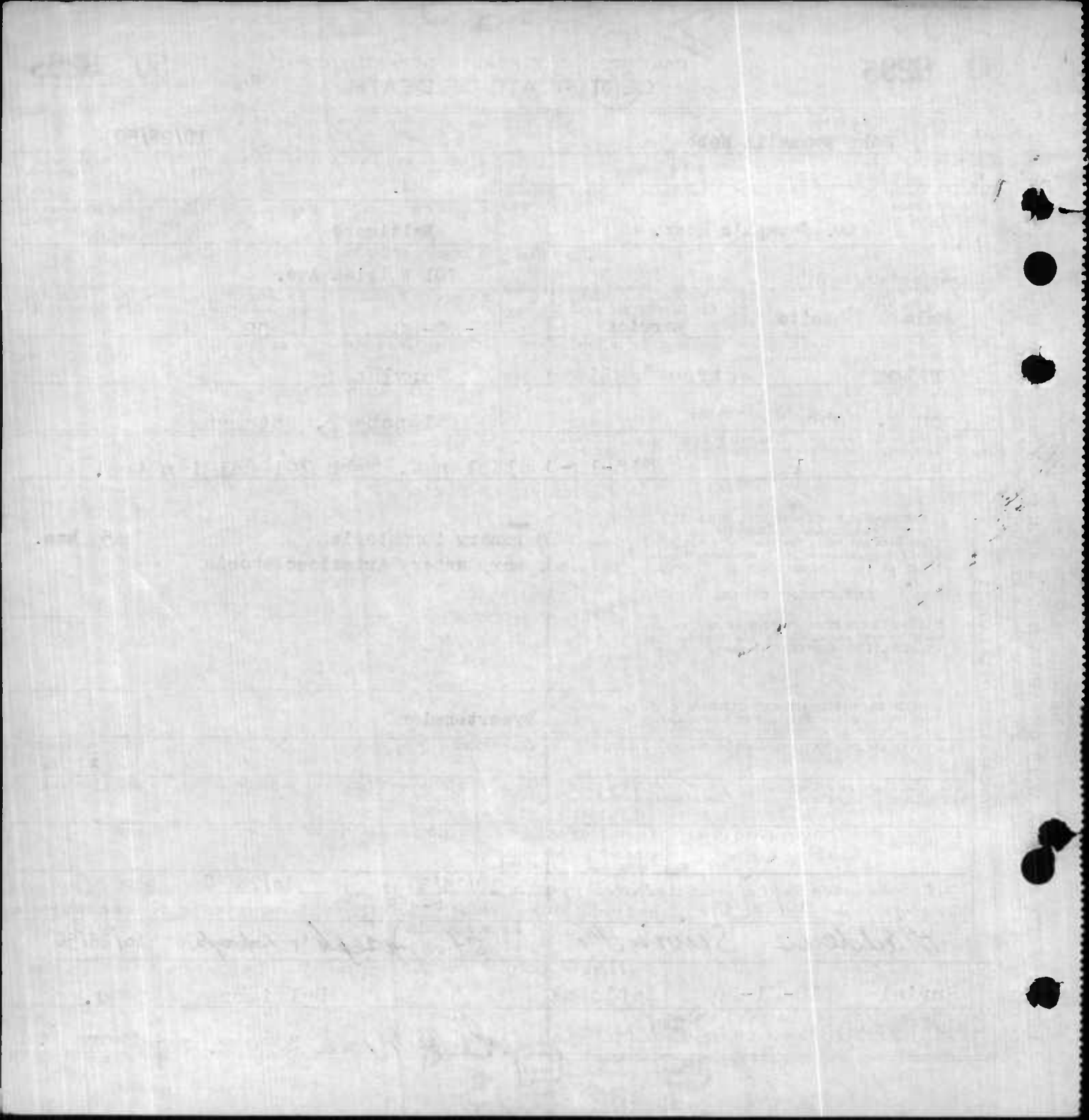
19A. DATE OF OPERATION 10/28/50		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/18/50 , to 10/28/50 , that I last saw the deceased alive on 10/28/50 , and that death occurred at 6-45P m., from the causes and on the date stated above.					
23A. SIGNATURE Maddens Swinski		23B. ADDRESS St. Joseph's Hosp.		23C. DATE SIGNED 10/28/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-31-50		24C. NAME OF CEMETERY OR CREMATORY National	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25. FUNERAL DIRECTOR John Q. Moran			
DATE RECEIVED BY LOCAL REGISTRAR Oct 30 1950		REGISTRAR'S SIGNATURE Thurston Williams		ADDRESS 3000 E. Baltimore St	

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

MARGIN RESERVED FOR BINDING

W-100



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

50 9296		BALTIMORE CITY HEALTH DEPARTMENT		50 9296	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>James Lucas</i>			2. DATE OF DEATH <i>October 28, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>15 S. Caroline St.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 3-01</i>		
C. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>15 S. Caroline St</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>July 4, 1853</i>	9. AGE (In years, last birthday) <i>97</i>	If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>Ellen?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Greene Conway 15 S. Caroline St</i>		
18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Chronic card. o - functional vascular disease</i> DUE TO (B) <i>arterio-sclerosis</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>?</i>
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 5, 1950</i> to <i>Oct. 28, 1950</i> that I last saw the deceased alive on <i>Oct. 28, 1950</i> and that death occurred at <i>10 A. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Wm. L. Perry</i>		23B. ADDRESS M. O. <i>1420 C. Chase</i>		23C. DATE SIGNED <i>10.30.50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct 31/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Am. Frederick Ch. Md.</i>		24D. LOCATION (City, town, or county) (State) <i>Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 30 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. L. Perry</i>		25. FUNERAL DIRECTOR ADDRESS <i>Mrs. R. H. A. Elliott & Daughter</i> <i>11297 N. Caroline St.</i> <i>131a</i>	

BOND

Detachable

2. 25.00 - 2. 25.00

2. 25.00

2. 25.00

2. 25.00

2. 25.00

2. 25.00

C-630 50 9297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9297
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Currid

2. DATE
OF
DEATH

October 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Mercy Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore - 4 Union

D. STREET ADDRESS (If rural, give location)

8504 Willow Oak Road 530

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 28, 1918

9. AGE (In years
last birthday)

32

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Trotter's Manager

10B. KIND OF BUSINESS OR
INDUSTRY

Warehouse

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William Snook

14. MOTHER'S MAIDEN NAME

Agnes Currid

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, oo or unknown) (If yes, give war or dates of service)

No.

NONE

16. SOCIAL
SECURITY NO.

216-10-1899

17. INFORMANT

ADDRESS

Mary Louise Currid

8504 Willow Oak Rd

18.

592X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B) Chronic Glomerular Nephritis

(C)

INTERVAL BETWEEN
ONSET AND DEATHseveral
yearsOTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 30, 1950, to Oct. 30, 1950 that I last saw the
deceased alive on Oct. 30, 1950, and that death occurred at 2:51 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John A. Spittel Jr., M.D.

23B. ADDRESS

Mercy Hosp

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 31 1950

Huntington Williams, M.D.

George L. Schwab 2101 Frederick Ave

VS 150

290 53

1316

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

STATE OF NEW YORK

1907

70

1907

70



50 9298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9298

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL ALBERT

2. DATE
OF
DEATH

10-30-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

3825 Park Heights Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3825 Park Heights Ave

c. Length of stay in Baltimore

60 Yrs.
mos.
days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

9. AGE (in years

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

76

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Reflected

10B. KIND OF BUSINESS OR INDUSTRY

Clothing Contractor

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Isadore

14. MOTHER'S MAIDEN NAME

Lena-

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Sadie Abramovitch - Same

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

arteriosclerotic heart disease - cardiac asthma

INTERVAL BETWEEN ONSET AND DEATH

Many years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerotic

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 18, 1950, to October 30, 1950, that I last saw the deceased alive on Oct. 28, 1950, and that death occurred at 2:54 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Halhaull Shpirtz

23B. ADDRESS

1810 Eutaw Pl.

23C. DATE SIGNED

10/30/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-31-50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

Wilmington Williams

25. FUNERAL DIRECTOR

Jack Lewis Inc 2100 Eutaw Pl

ADDRESS

VS 150

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully and legibly. The correct age is especially important. Physicians write the causes of death clearly and legibly.

Aperty
1810 661119
Ka 3788

12-250 50 9299

50 9299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SHIRLEY KASSEN		2. DATE OF DEATH 10-30-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION Levindale		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-03			
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 7251 Greenmount Ave			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 37	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME Carl		14. MOTHER'S MAIDEN NAME Elizabeth		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Herman Kassen - Same	

MEDICAL CERTIFICATION

18. 204.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic myelogenous leukemia		INTERVAL BETWEEN ONSET AND DEATH 2 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-26 1950 , to 10-30 1950 , that I last saw the deceased alive on 10-30 1950 , and that death occurred at 6:05 a.m. , from the causes and on the date stated above.					
23A. SIGNATURE Harry Nagel		23B. ADDRESS Levindale Home		23C. DATE SIGNED 10-30-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-31-50		24C. NAME OF CEMETERY OR CREMATORY St. Ignace	
24D. LOCATION (City, town, or county) (State) Balto Md		25. FUNERAL DIRECTOR Jack Lewis Inc 2100 Canton Rd			
DATE RECEIVED BY LOCAL REGISTRAR OCT 31 1950		REGISTRAR'S SIGNATURE Wilmington Williams			

VS 150

174a

MARGIN RESERVED FOR BINDING
PLEASE WRITE IN PENCIL, WITH UNFADING INK. Every item of information should be applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

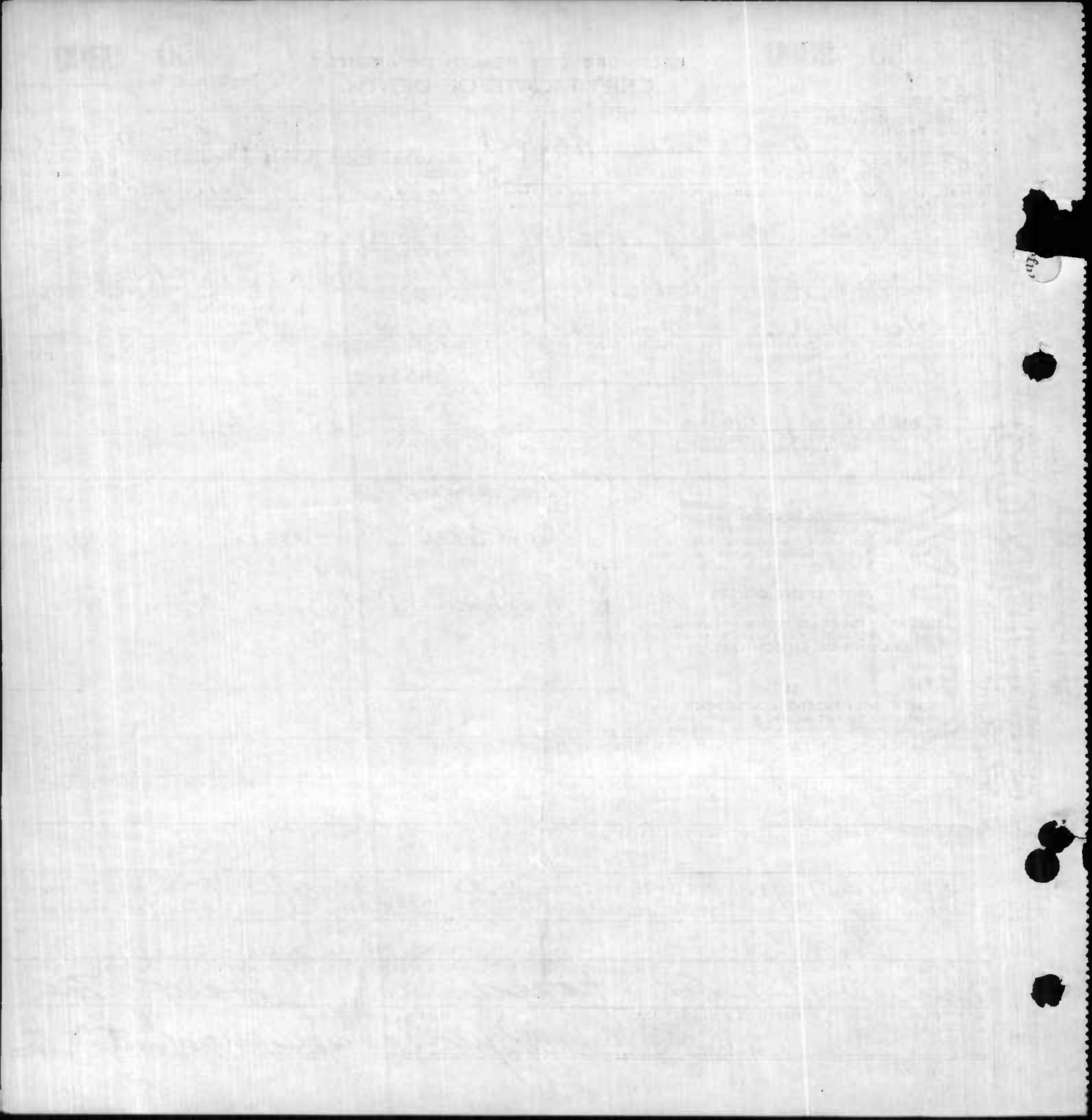
VALLEY
HONGKONG
BOUND

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9300
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Goodstein, Rachel</i>		2. DATE OF DEATH <i>Oct 31, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home & Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 13-02</i>			
C. Length of stay in Baltimore <i>7 Years</i>		D. STREET ADDRESS (If rural, give location) <i>2107 Brookfield Ave.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>1878</i>	9. AGE (In years last birthday) <i>72</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Schlein, Moses</i>		14. MOTHER'S MAIDEN NAME <i>Brenda</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO	<i>Several years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10/23</i> , 19 <i>50</i> , to <i>10/31</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>10/30</i> , 19 <i>50</i> , and that death occurred at <i>3:30</i> A.M., from the causes and on the date stated above.					
23A. SIGNATURE <i>Wheed Carroll</i>		23B. ADDRESS <i>Church Home & Hospital</i>		23C. DATE SIGNED <i>10/31/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-1-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25. FUNERAL DIRECTOR ADDRESS <i>2100 East Ave</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 31 1950</i>		REGISTRAR'S SIGNATURE <i>W. Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>2100 East Ave</i>	



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILHELMINA(Minnie) S. SEIDLER

2. DATE
OF
DEATH

Oct. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

2734 The Alameda

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2734 The Alameda

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 9, 1871

9. AGE (In years,
last birthday)

79

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

nurse - ret. 30 yrs

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George W. Seidler

14. MOTHER'S MAIDEN NAME

Sophie Ide

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT 2734 The Alameda

Mrs Emma Hanauer

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Acute Cardiac Failure

1 da

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Generalized Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Cardiovascular Renal Disease

10 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/10, 1950, to 10/28, 1950, that I last saw the
deceased alive on 10/28, 1950 and that death occurred at 10:00 am, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

burial

10/31/50

Woodlawn Cemetery

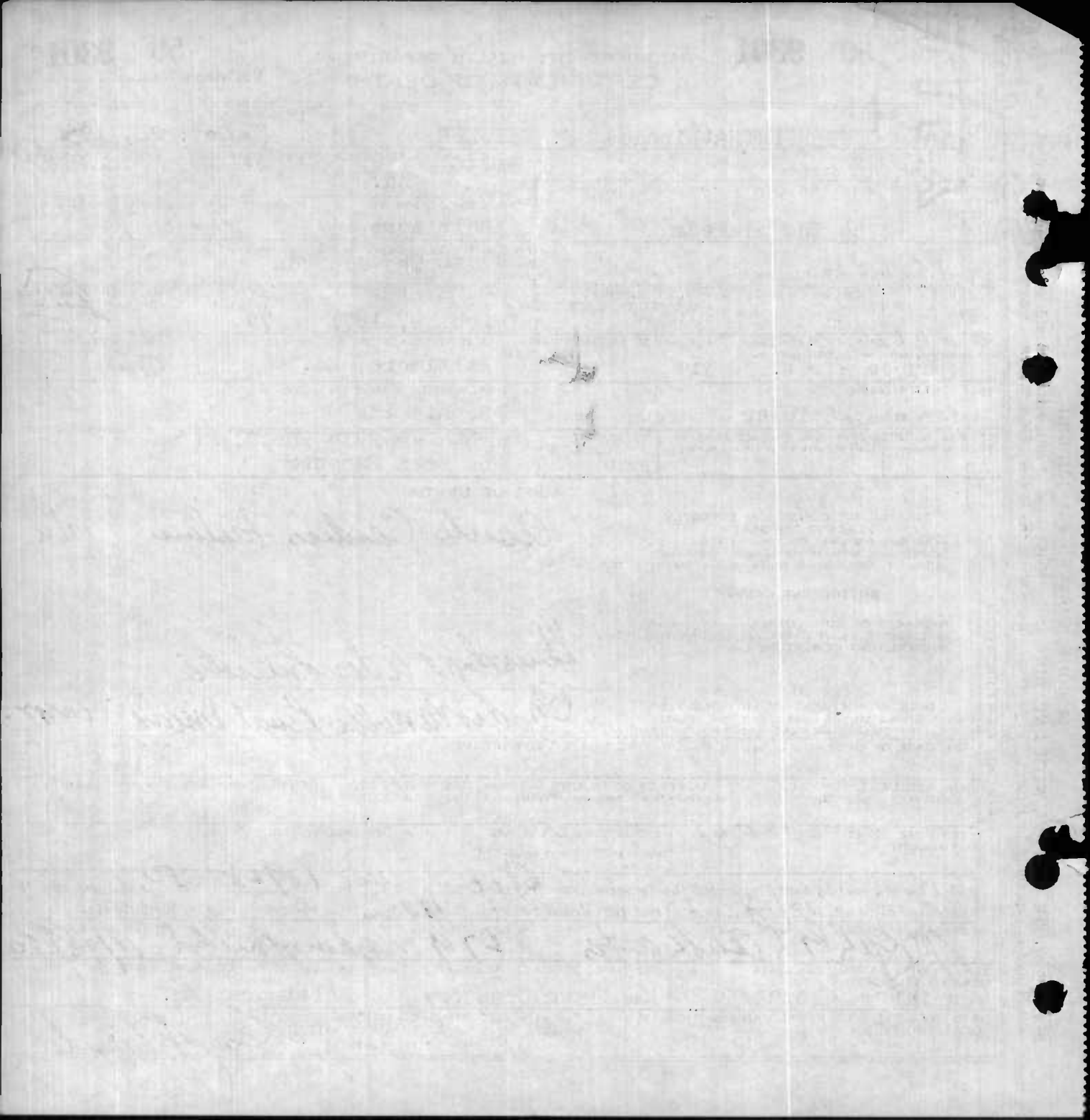
Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

HENDERSON & SONS, INC. ADDRESS

BALTO., 13, MD.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Irene Johnson*2. DATE
OF
DEATH*10/30/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME-OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. *331X*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Oct 30, 1950*, to *Oct 30, 1950*, that I last saw the
deceased alive on *Oct 30, 1950*, and that death occurred at *2:15 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

The following is a list of the
 names of the persons who
 were present at the meeting
 held on the 1st day of
 January, 1900, at the
 residence of Mr. J. H.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9303

BIRTH NO. 50 9303

1. NAME OF DECEASED
(Type or Print)

Joseph S. Clark

2. DATE
OF
DEATH Oct. 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1337 Clipper Heights Avenue

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1337 Clipper Heights Avenue

c. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

March 2, 1882

9. AGE (In years
last birthday)

68

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Maintenance Man

10B. KIND OF BUSINESS OR
INDUSTRYTWINE (M) INDUSTRY
Mt. Vernon Woodberry

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Mary E. ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

216-89-9457

17. INFORMANT

ADDRESS

Mrs. Lula M. Clark, 1337 Clipper Heights

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) ...
DUE TO

Coronary Thrombosis

4da.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) ...
DUE TO

Atherosclerotic CVD & Hypertension

?

(C) ...

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1946, to Oct 30, 1950, that I last saw the
deceased alive on Oct 20, 1950 and that death occurred at 6:57 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Lawrence J. Flannery

M. D.

23B. ADDRESS

3711 Bell Rd

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11/1/50

24C. NAME OF CEMETERY OR CREMATORY

Meadow Ridge

24D. LOCATION (City, town, or county)

Dorsey,

Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Harrison, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Stm. Cook Inc, 1217 St. Paul Street

OCT 31 1950

VS 150

5544F

093d

100

100-200-2

100

AVLLEA

100-200-2

100-200-2

100-200-2

100-200-2

100-200-2

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100-200-2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9304

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES RYAN

2. DATE
OF
DEATH

October 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

5. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

27-10

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1101 Woodbourne Avenue

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 24, 1889

9. AGE (In years
last birthday)

61

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Comm. Broker

10B. KIND OF BUSINESS OR
INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William A. Ryan

14. MOTHER'S MAIDEN NAME

Mary Ellen Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Thomas E. Ryan, Park Ryan Apartments

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. V. V.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

M.D.

MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Oct. 30, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

H. M. Cook, Inc.

1217 St. Paul Street

VS 151

29072

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be so applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 20

WESTERN UNION TELEPHONE
CITY OF NEW YORK

NOV 20



50 9305

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9305

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK GRAVENSTEIN

2. DATE
OF
DEATH

10-28-56

3. PLACE OF DEATH:

A. Baltimore City, Maryland - SINAI HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

A. STATE BALT-MD

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt - MD 17-04

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1604 Hollins Ave HOLLINS ST

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

OCT. 15 1891

9. AGE (In years
last birthday)

59

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HUCKSTER

10B. KIND OF BUSINESS OR
INDUSTRY

OWN

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

FRANK GRAVENSTEIN

14. MOTHER'S MAIDEN NAME

BELLE CUNNINGHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JAMES GRAVENSTEIN 1828 HENNEMAN AVE

18. 416X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Rheumatic Heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Chronic congestive failure

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-4, 1950, to 10-28, 1950 that I last saw the
deceased alive on 10-28, 1950, and that death occurred at 5:20 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry C. Stefan

M. O.

23B. ADDRESS

Sinai Hosp. - Baltimore

23C. DATE SIGNED

10-28-56

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

NOV. 1, 1950

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE

24D. LOCATION (City, town, or county)

BALTIMORE, MD.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR,

ADDRESS

Williams & Cook, Inc. 1217 ST. PAUL ST.

[Faint, illegible text and markings on a lined form, possibly a medical or administrative document.]



50 9306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9306

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

OLA

LAMB

2. DATE
OF
DEATH

October 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE
Florida

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Miami

D. STREET ADDRESS (If rural, give location)

246 - 20th Street, N. W.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 23, 1903

9. AGE (In years
last birthday)

47

11 Under 1 Year
Months Days12 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Florida

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James Gordon

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

M's Adell McCoy P.O.#164 Meerifield Va.

18. E 8+3.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary embolus

DUE TO thrombophlebitis of veins of right
leg

(B) Fracture of right femur

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☒ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Public

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Route #1, 1 mi. north of Waterloo barracks

21D. TIME (Month) (Day) (Year) (Hour)

October 15, 1950 7 A. m.

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto--struck telephone pole

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Quisenberry, M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11-4-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

Miami, Florida.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 31 1950

Washington Williams, M.D.

Met Frances A. Hensley

312 W. Biddle St.

VS 151

N 821.0

170c

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3388 02

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of medical examiner		19. Signature of pathologist		20. Signature of anatomist	
21. Signature of coroner		22. Signature of jury		23. Signature of witness		24. Signature of burial place	
25. Signature of funeral director		26. Signature of undertaker		27. Signature of cemetery		28. Signature of burial place	
29. Signature of health officer		30. Signature of medical examiner		31. Signature of pathologist		32. Signature of anatomist	
33. Signature of coroner		34. Signature of jury		35. Signature of witness		36. Signature of burial place	
37. Signature of funeral director		38. Signature of undertaker		39. Signature of cemetery		40. Signature of burial place	
41. Signature of health officer		42. Signature of medical examiner		43. Signature of pathologist		44. Signature of anatomist	
45. Signature of coroner		46. Signature of jury		47. Signature of witness		48. Signature of burial place	
49. Signature of funeral director		50. Signature of undertaker		51. Signature of cemetery		52. Signature of burial place	
53. Signature of health officer		54. Signature of medical examiner		55. Signature of pathologist		56. Signature of anatomist	
57. Signature of coroner		58. Signature of jury		59. Signature of witness		60. Signature of burial place	
61. Signature of funeral director		62. Signature of undertaker		63. Signature of cemetery		64. Signature of burial place	
65. Signature of health officer		66. Signature of medical examiner		67. Signature of pathologist		68. Signature of anatomist	
69. Signature of coroner		70. Signature of jury		71. Signature of witness		72. Signature of burial place	
73. Signature of funeral director		74. Signature of undertaker		75. Signature of cemetery		76. Signature of burial place	
77. Signature of health officer		78. Signature of medical examiner		79. Signature of pathologist		80. Signature of anatomist	
81. Signature of coroner		82. Signature of jury		83. Signature of witness		84. Signature of burial place	
85. Signature of funeral director		86. Signature of undertaker		87. Signature of cemetery		88. Signature of burial place	
89. Signature of health officer		90. Signature of medical examiner		91. Signature of pathologist		92. Signature of anatomist	
93. Signature of coroner		94. Signature of jury		95. Signature of witness		96. Signature of burial place	
97. Signature of funeral director		98. Signature of undertaker		99. Signature of cemetery		100. Signature of burial place	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

SOBOLESKI

2. DATE
OF
DEATH

October 29, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1514 Cypress Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

25-05

D. STREET ADDRESS (If rural, give location)

1514 Cypress Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 25, 1878

9. AGE (In years
last birthday)

71

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR
INDUSTRY

Chemical Co. (M)

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Teofil Soboleski

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
217-05-4716

17. INFORMANT

Alexandra

ADDRESS

Soboleski 1514 Cypress St

18. E 900.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Skull fracture

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Intracranial Hemorrhage

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1514 Cypress Street

25/5

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

October 29, 1950 8:45P.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down cellar steps, inside

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William W. Smith

23B. CHIEF MEDICAL EXAMINER.....

M.D. ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

Oct. 30, 1950

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

Burial

24B. DATE

Nov. 3-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

A. A. Co. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

Oct 31 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Fialkowski 2007 Eastern Ave

ADDRESS

VS 151

N 803.2

5104R

1862

1007

1007

GRAND JURY CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1007

1007

1007

1007

1007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anna KOWELL

2. DATE
OF
DEATH

10/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2031 E. PRATT

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE 2031 E. PRATT ST. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

201

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Not know

9. AGE (In years last birthday)

59

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Russian

12. CITIZEN OF WHAT COUNTRY?

✓

13. FATHER'S NAME

Not know

14. MOTHER'S MAIDEN NAME

Not know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Anna Szymanski

ADDRESS

107.0 Pratt St

18. 491X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute Bronchopneumonia

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

4 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 27, 1950, to Oct 29, 1950, that I last saw the deceased alive on Oct 29, 1950, and that death occurred at 11:00 m., from the causes and on the date stated above.

23A. SIGNATURE

Walter J. Stender

M. D.

23B. ADDRESS

2000 5th St

23C. DATE SIGNED

10/31/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Trinity Russian

24D. LOCATION (City, town, or county)

Elderidge Md

(State)

DATE RECEIVED BY LOGAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

Walter J. Stender

FUNERAL DIRECTOR

D.A. Grubbs

ADDRESS

1905 E. Pratt St

10/29/50

2031 E. TRAIL ST

BARTIMORE

CLARENCE HOWELL

2031 E. TRAIL ST

29

RECEIVED

TRAIL ST

NEW YORK

RECEIVED

HOME

TRAIL ST

RECEIVED

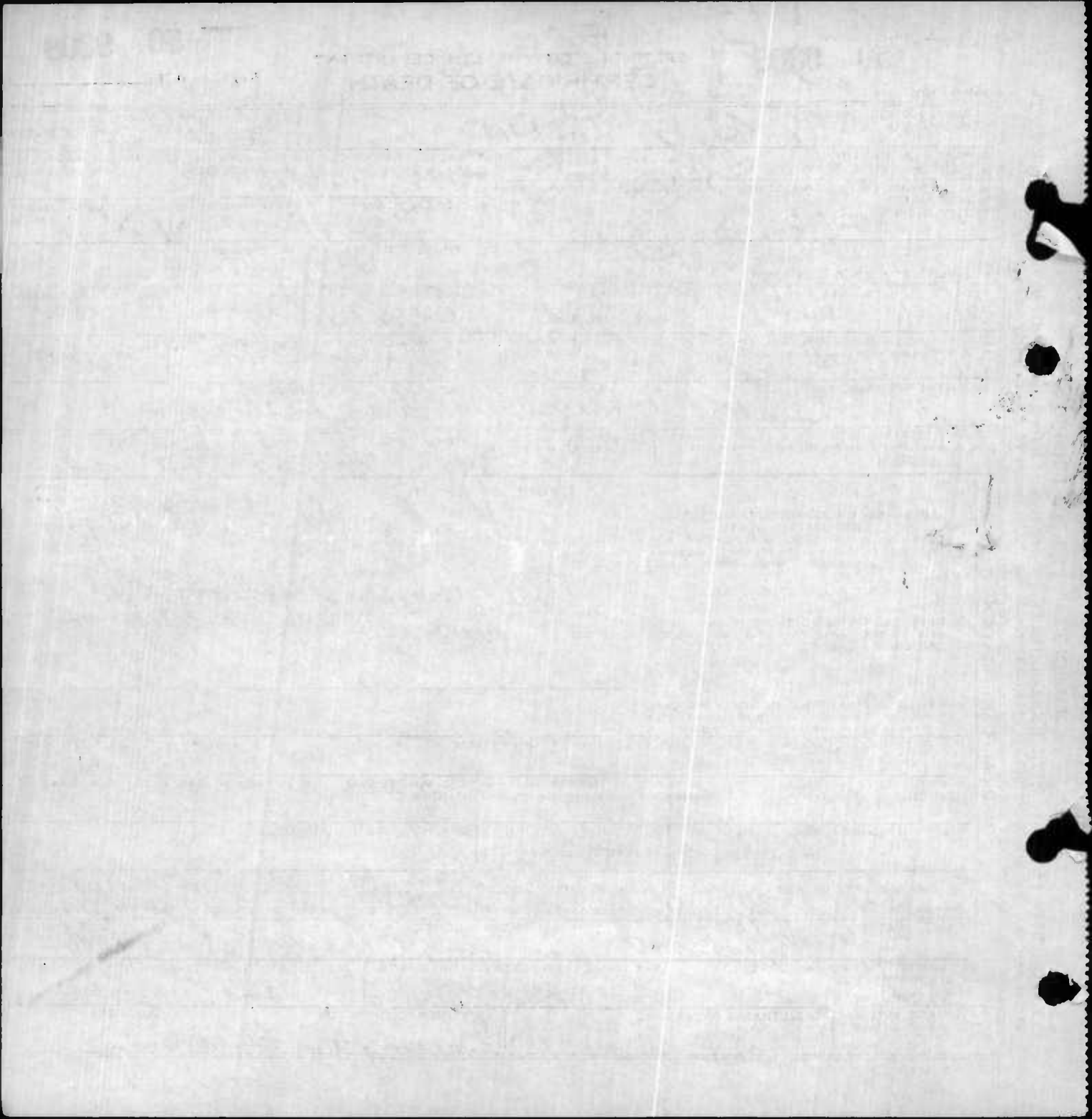
TRAIL ST

TRAIL ST

RECEIVED 11/2/50
NEW YORK
TRAIL ST

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HARRY G WATKINS		2. DATE OF DEATH OCT 30 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY MD			
B. FULL NAME OF HOSPITAL OR INSTITUTION THE MERCY HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE MD			
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) Maryland			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7/12/1873	9. AGE (In years last birthday) 77	H Under 1 Year Months: Days H Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRANSMISSION TESTER		10B. KIND OF BUSINESS OR INDUSTRY C.F.P. Tel. Co		11. BIRTHPLACE (State or foreign country) Balto Md.	
13. FATHER'S NAME John Beale Watkins		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO.		17. INFORMANT Lillian R Watkins	
				ADDRESS 2927 W North Ave	

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Ventricular Fibrillation i hr		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO Arteriosclerotic Cardiovascular Disease c Myocard Infarction			
(B) DUE TO					
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 24 1950 to Oct 30 1950 , that I last saw the deceased alive on Oct 30 1950 , and that death occurred at 11:05 Am. , from the causes and on the date stated above.					
23A. SIGNATURE Frank G. Karik		23B. ADDRESS 3630 Elkhader Rd.		23C. DATE SIGNED 10/30/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burd		24B. DATE 11-2-50		24C. NAME OF CEMETERY OR CREMATORY First Methodist Church Cem	
24D. LOCATION (City, town, or county) (State) FORTH MD		24E. FUNERAL DIRECTOR Howard Strong		24F. ADDRESS 3207 W North Ave	
DATE RECEIVED BY LOCAL REGISTRAR OCT 31 1950		REGISTRAR'S SIGNATURE William H. ...		25. FUNERAL DIRECTOR Howard Strong	



RECEIVED FOR BINDING

The information should be carefully checked and applied. Every item of information should be carefully checked and applied. This: please write the causes of death clearly and legibly.

F 655

50 9310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9310

Registered No. _____

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Frances R. Foreman		2. DATE OF DEATH 10-29-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY _____			
B. FULL NAME OF (If not in hospital or institution, give street address or location) 2447 Maryland Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md. 12-06			
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 2447 Md. Ave.			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7-26-99	9. AGE (In years last birthday) 51	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or oookown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Charles O Foreman 2447 Maryland Ave	
18. 170X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Carcinoma of the breast DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH 15 moe
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
I hereby certify that I attended the deceased from July 15 , 19 49 , to Oct 29 , 19 50 , that I last saw the deceased alive on Oct 29 , 19 50 , and that death occurred at 11:45 p.m. , from the causes and on the date stated above.					
A. SIGNATURE M. H. Butterman		23B. ADDRESS 2324 Reisterstown Rd		23C. DATE SIGNED Oct 30, 1950	
24B. DATE 11-1-50		24C. NAME OF CEMETERY OR CREMATORY Orem		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
RECEIVED BY REGISTRAR 311950		REGISTRAR'S SIGNATURE Thurston Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS 403 S. Wolfe Street.	

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10-5-50

Handwritten signature

D-250 50 9311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9311
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Dixon

2. DATE
OF
DEATH

10-28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto 7112

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1307 N. Central ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto

9-09

c. Length of stay in Baltimore

21

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1307 N. Central ave

5. SEX

Male

6. COLOR OR RACE

Col

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7-4-1904

9. AGE (In years last birthday)

46

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

GEN.

11. BIRTHPLACE (State or foreign country)

N. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Abel Dixon

14. MOTHER'S MAIDEN NAME

Lucy Haskin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

705-10-9505

17. INFORMANT

ADDRESS

Ruth Dixon 1307 N. Central

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21-1950, to 10-28-1950, that I last saw the deceased alive on 10-27-1950, and that death occurred at 5:15 m., from the causes and on the date stated above.

23A. SIGNATURE

J. Edward Fisher

M. D.

23B. ADDRESS

1612 2nd Monument St

23C. DATE SIGNED

10-28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 1, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Oliver

24D. LOCATION (City, town, or county)

N. Carolina

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Gottlieb Gross 1408 Ashland Ave

ADDRESS

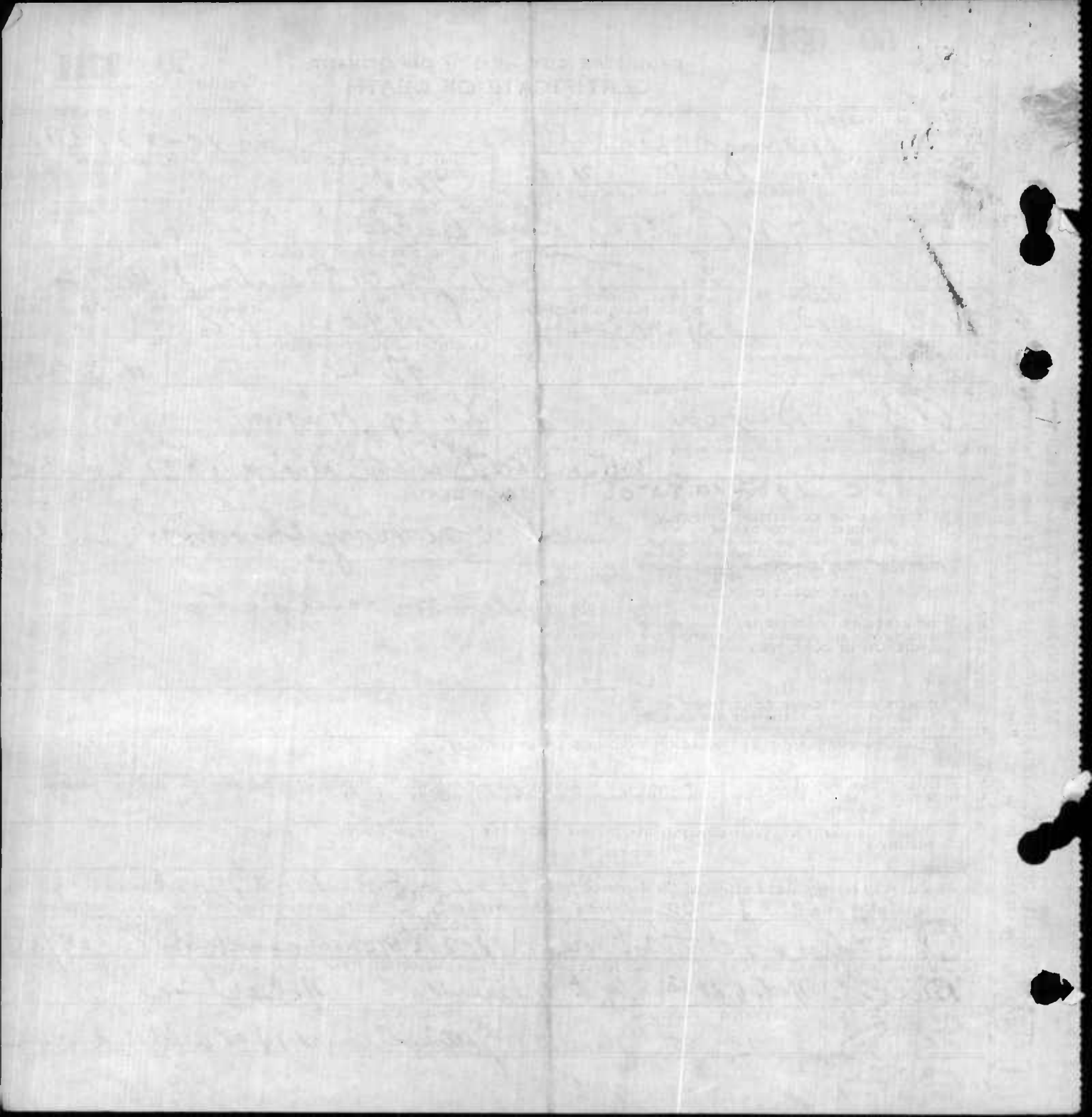
Oct 31 1950

97099

094a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES WESLEY (HAMLET)

HAMMOND

2. DATE
OF
DEATH

October 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
MarylandB. COUNTY
Anne ArundelB. FULL NAME OF (If not in hospital or institution, give street address or
location)HOSPITAL OR
INSTITUTION South Baltimore General Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give
township)

Linthicum Heights

D. STREET ADDRESS (If rural, give location)

Hanover Road

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 10, 1910

9. AGE (In years
last birthday)

40

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRYFlower
Nursery

11. BIRTHPLACE (State or foreign country)

Stoney Run, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James W. Hammond

14. MOTHER'S MAIDEN NAME

Mary Gamble

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No.

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Hazel Hammond Linthicum Heights, Md.

18. E812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple fractures, lacerations,
abrasions, and contusions
DUE TO

ANTECEDENT CAUSES

(B) Fracture of neck
DUE TODISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Road

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Crane Highway, 3 1/2 mi. S. of Glen Burnie

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

October 27, 1950 10:20 P.m.

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thercon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Dinschlag M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

10-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-31-1950

24C. NAME OF CEMETERY OR CREMATORY

Cooks Cemetery

24D. LOCATION (City, town, or county)

Harmans Md.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

T. Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. Kate R. Williams

ADDRESS

322 N. Schroeder

VS 151

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170 C

✓

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100-1015

BALTIMORE CITY HEALTH DEPARTMENT

100-1015

CERTIFICATE OF DEATH

Residence No.

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

B-650
50 9313BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9313

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James E. Brown.

2. DATE
OF
DEATH

October 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1418 W. Franklin St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 19-01

D. STREET ADDRESS (If rural, give location)

1418 W. Franklin St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Feb. 12, 1876.

9. AGE (In years,
last birthday)

74

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Construction Work

11. BIRTHPLACE (State or foreign country)

Buchingham Co. Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown.

14. MOTHER'S MAIDEN NAME

Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Ernest W. Brown. 1418 W. Franklin

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive Type Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CERTIFICATION APPROVED BY

John R. Davis

Per: William H. Smith

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/28, 1950 to 10/28, 1950 that I last saw the
deceased alive on 10/28, 1950, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Evan A. Brice

23B. ADDRESS

601 N. Calhoun St.

23C. DATE SIGNED

10/30/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Nov. 4, 1950

Mt. Auburn Cem

Balto.

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

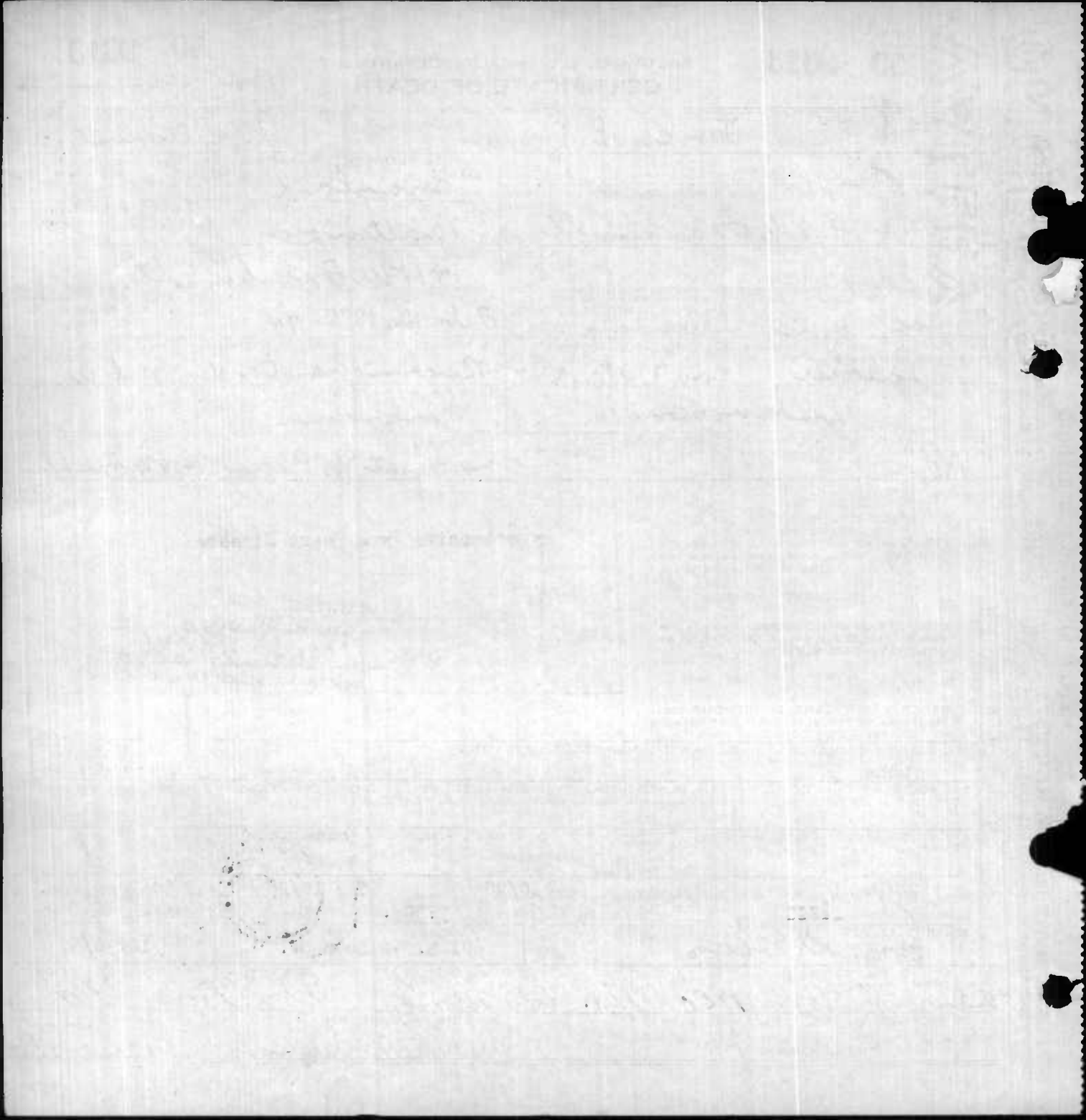
ADDRESS

OCT 31 1950

Huntington Williams, M.D.

Mrs. Katie B. Williams

Schroeder St.



50 9314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9314

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Miss Anna Gleason

2. DATE
OF
DEATH

10-30-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Bon Secours Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. - 19-04

D. STREET ADDRESS (If rural, give location)

1839 W. Baltimore St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

1850

9. AGE (In years

last birthday)

80?

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Gleason

14. MOTHER'S MAIDEN NAME

Mary Crowley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Florence Michael York Rd

ADDRESS

18. 450.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Gangrene of left foot.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-23, 1954 to 10-30, 1956, that I last saw the deceased alive on 10-30, 1956, and that death occurred at 8.50 pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

Bon Secours Hospital

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Baltimore City

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John J. Gleason & Son

ADDRESS

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

DEATH CERTIFICATE

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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PREVIOUS OTHER

R-152

50 9315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9315
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William H. Robinson

2. DATE
OF
DEATH

Oct. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

634 N. Gilmore St

D. STREET ADDRESS (If rural, give location)

634 N. Gilmore St

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months Days
If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY No.

17. INFORMANT

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension

?

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Sept 30, 1950, to Oct 29, 1950, that I last saw the
deceased alive on Sept 30, 1950, and that death occurred at 12 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 31 1950

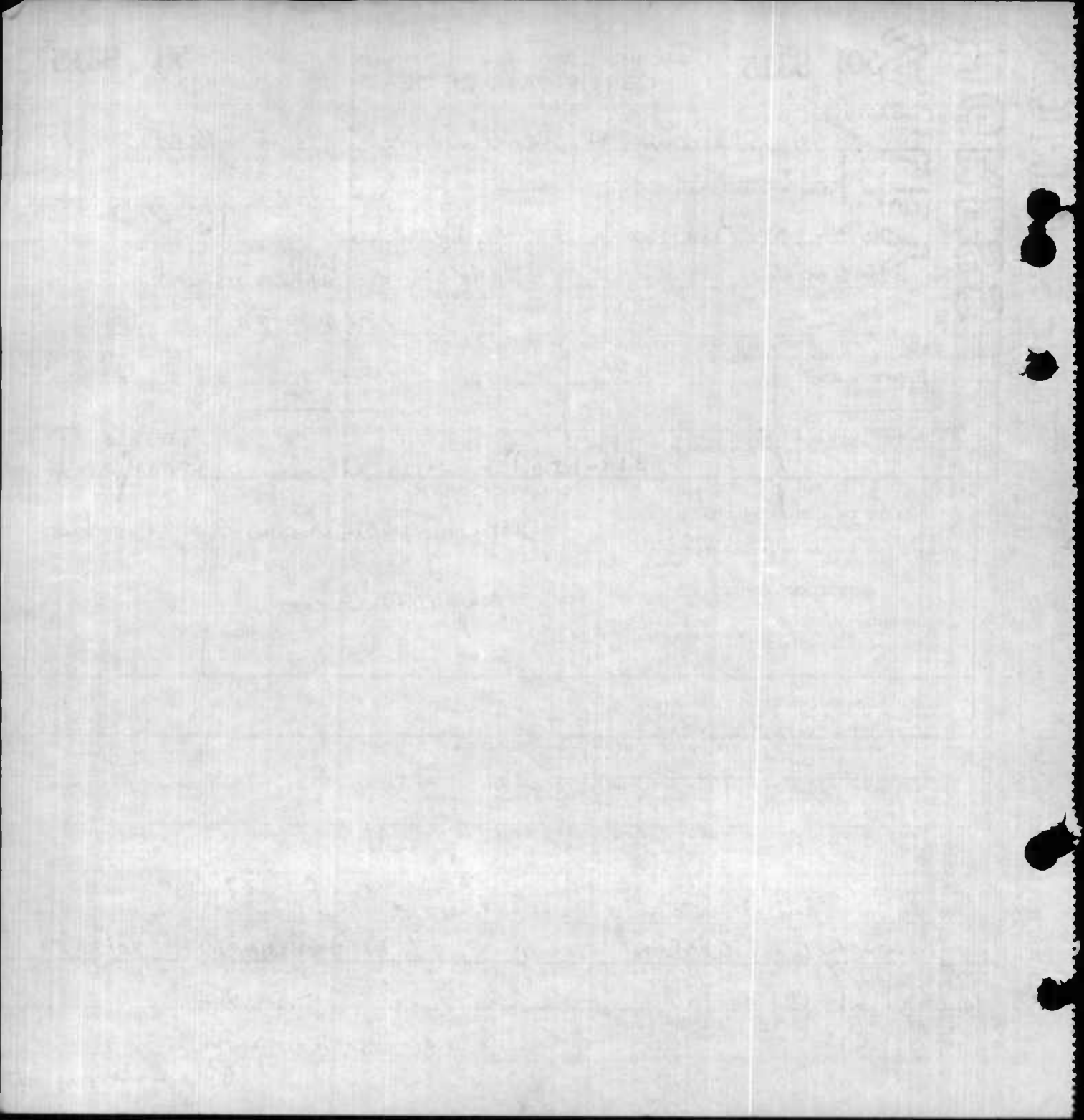
VS 150

97099

Preselman St
094a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



300
50 9316BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9316

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) JOHN THOMAS CUPDY			2. DATE OF DEATH 10/29/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSP			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 443 E. GITTINGS ST.		
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 16, 1893		9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10B. KIND OF BUSINESS OR INDUSTRY B & O. R.R.		11. BIRTHPLACE (State or foreign country) Balto. Md.
13. FATHER'S NAME Michael J. Cuddy			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT ADDRESS Barbara Cuddy - 443 E. Gittings St.		

18. **331X**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)CAUSE OF DEATH
Cerebral hemorrhage
Hypertension and
arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10/28/50**, to **10/29/50**, that I last saw the deceased alive on **10/29/50**, and that death occurred at **6P** m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

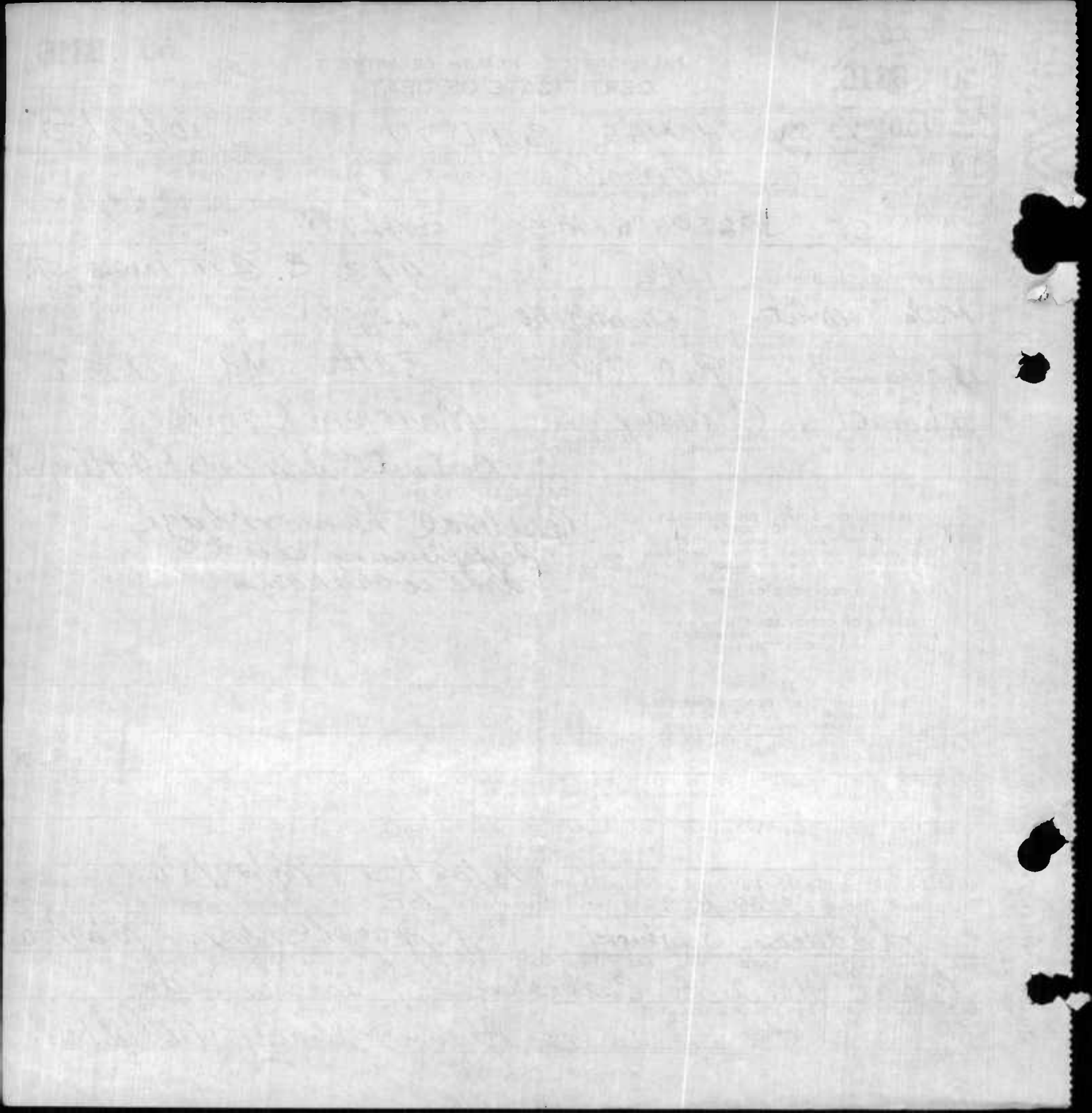
(State)

DATE RECEIVED BY LOCAL REGISTRAR
OCT 31 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



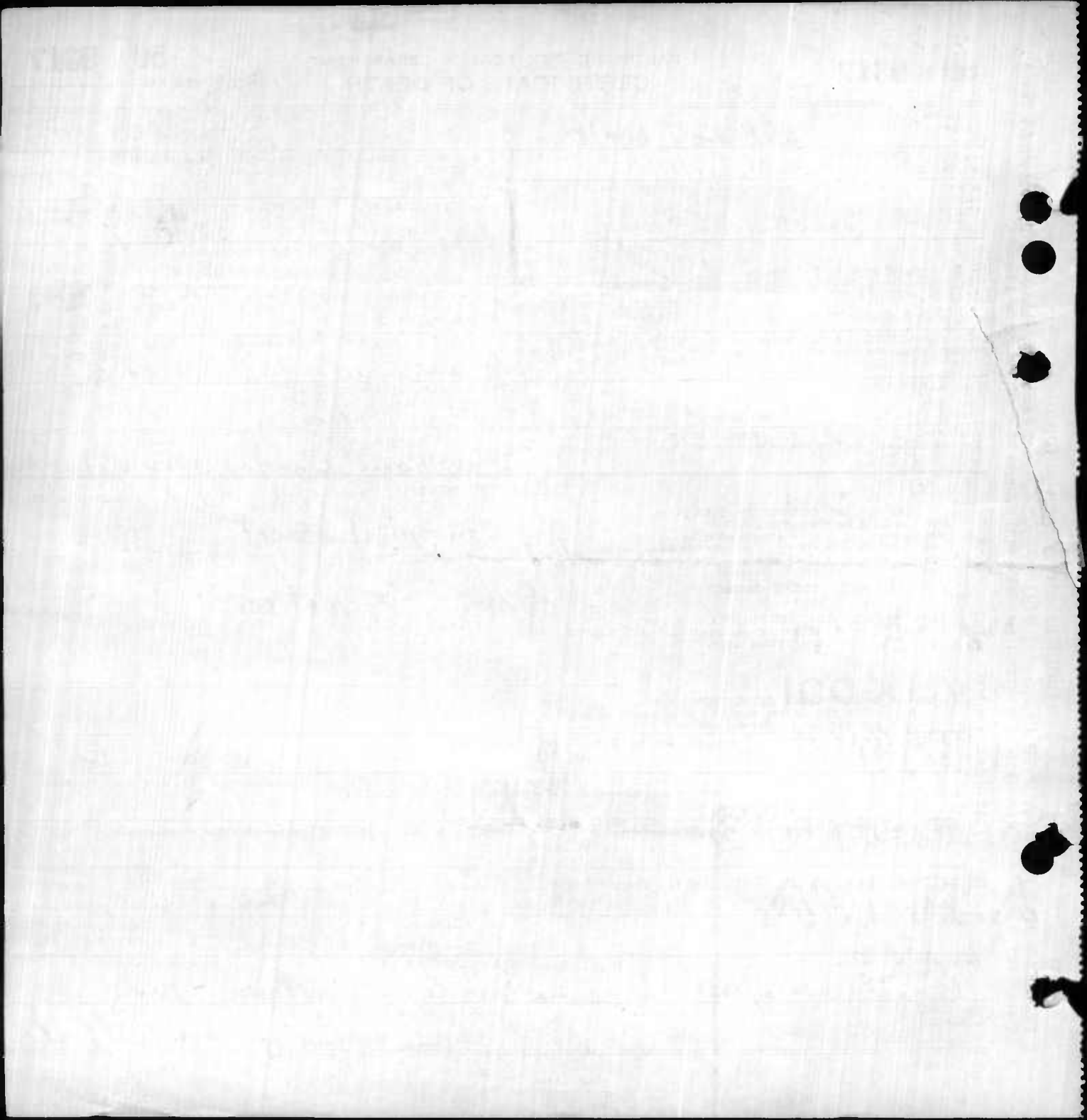
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9317
Registered No.

BIRTH NO. 50-22945

1. NAME OF DECEASED (Type or Print) <i>William Charles Gordon</i>			2. DATE OF DEATH 10-29-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Bon SECOURS Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE 27-05</i>		
C. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>3902 WALNUT AVE</i>		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>	8. DATE OF BIRTH <i>10-21-50</i>	9. AGE (In years last birthday) <i>8</i>	10. Under 1 Year Months: Days: <i>8</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William Charles Gordon</i>			14. MOTHER'S MAIDEN NAME <i>Mary P. Hart</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>William C. Gordon</i>			ADDRESS <i>3902 Walnut Ave</i>		

18. <i>754.4</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	(A) <i>Congenital Heart</i>	
ANTECEDENT CAUSES	(B) <i>Mal. Formation.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>2</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED M. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>10/21</i> 19 <i>50</i> , to <i>10/29</i> 19 <i>50</i> , that I last saw the deceased alive on <i>10/29</i> 19 <i>50</i> , and that death occurred at <i>9:15</i> m., from the causes and on the date stated above.		
23A. SIGNATURE <i>Edward M. Galick</i>	23B. ADDRESS <i>Bon Secours Hospital</i>	23C. DATE SIGNED <i>10/30/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/31/1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cms</i>
24D. LOCATION (City, town, or county) (State) <i>Ind.</i>	25. FUNERAL DIRECTOR <i>Flynn & Fleming</i>	ADDRESS <i>1426 High St.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 31 1950</i>		
REGISTRAR'S SIGNATURE <i>William C. Gordon</i>		



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9318

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CAREY

GROSS

2. DATE
OF
DEATH

October 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits write RURAL and give township)

Baltimore

HOSPITAL OR INSTITUTION

D. STREET ADDRESS (If rural, give location)

430 Moore Street

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

?? 1898

9. AGE (In years

last birthday)

53

54

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Coal Truck

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Walter Gross

14. MOTHER'S MAIDEN NAME

Mary Ross

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

217-07-035

17. INFORMANT

Carrie Gross - 430 - Moore St

ADDRESS

18. 443 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Burleson M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

Oct. 31, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11-3-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

W. H. Hallett - 918 -

ADDRESS

68367

VS 151

68367

Hendricks Hill Ave.

093d

1912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1912

CERTIFICATE OF DEATH

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9319
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Charles J. Abendschein</i>			2. DATE OF DEATH <i>Oct 30th 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>4100 Florenton Road</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balto</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>—</i>			C. CITY OR TOWN (If outside corporate limits, write full name, and give township) <i>16-08</i>		
C. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>4100 Florenton Road</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 6th 1904</i>	9. AGE (In years last birthday) <i>46</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Operator Mutual Chemicals</i>			11. BIRTH PLACE (State or foreign country) <i>Md</i>		
13. FATHER'S NAME <i>John Abendschein</i>			14. MOTHER'S MAIDEN NAME <i>Mary Rader</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mrs Emma Abendschein</i>			ADDRESS <i>4100 Florenton Rd</i>		

18. <i>162X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>01/22/51</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Carcinoma bronchogenic</i>		
DUE TO		(B)		
DUE TO		(C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>15 Nov</i> , 1949 to <i>30 Oct</i> , 1950, that I last saw the deceased alive on <i>29 Oct</i> , 1950, and that death occurred at <i>home</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Howard J. [illegible]</i>		23B. ADDRESS <i>1513 N. [illegible]</i>		23C. DATE SIGNED <i>30 Oct 50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>Nov 1st 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St Matthews Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>St Est</i>		25. FUNERAL DIRECTOR <i>Lead B. [illegible]</i>		ADDRESS <i>1701-03 N. Patterson Park Ave</i>	

VS 150

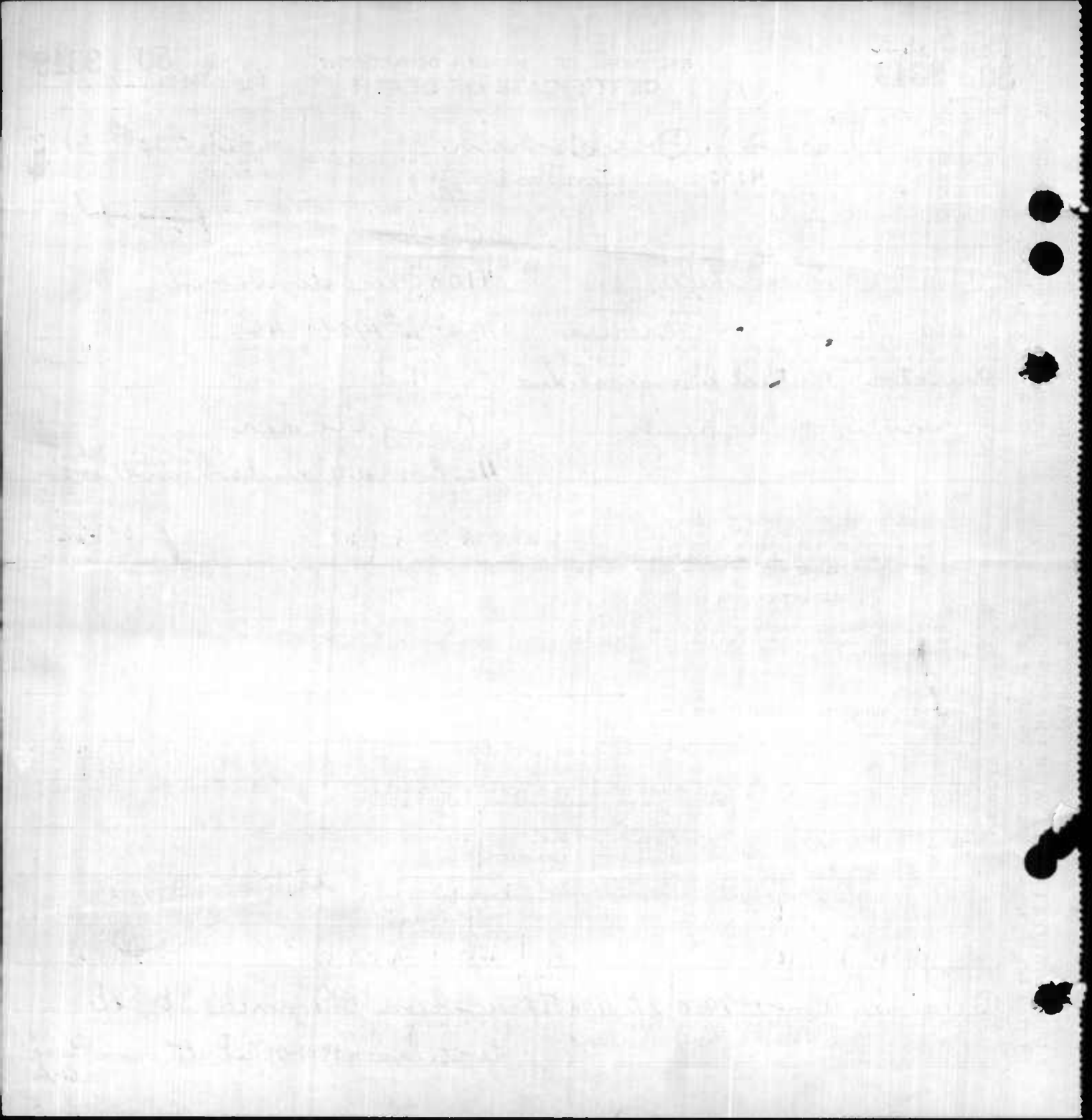
690 4R

047c

Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



D-250

50 9320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9320

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>Albert Dickson (Dixon)</u>		2. DATE OF DEATH <u>October 27, 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 5-01</u>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <u>112 N. Caroline St.</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>2-11-04</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lamp Lighter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Auto Street Highway</u>	9. AGE (In years last birthday) <u>46</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>Thomas Dickson</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-65-5306</u>	
17. INFORMATION <u>JOHNS HOPKINS HOSPITAL</u>		ADDRESS _____	

18. <u>322.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <u>Cerebro-cortical atrophy</u> DUE TO (B) <u>Chronic alcoholism</u> DUE TO (C) <u>Chronic malnutrition</u>	INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-25, 1950, to 10-27, 1950, that I last saw the deceased alive on 10-27, 1950, and that death occurred at 10 P.m., from the causes and on the date stated above.

23A. SIGNATURE <u>Victor G. McFadden</u> M. D.	23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	23C. DATE SIGNED <u>10-28-50</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Nov-1-1950</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Map. Auburn</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT 31 1950</u>	REGISTRAR'S SIGNATURE <u>Thurston Williams</u>	25. FUNERAL DIRECTOR <u>Holland Funeral Home</u>	

VS 150

6905C 1631-Daniel Hill Ave. 077d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9321

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) **EMMETT CLYDE (BOLDON) --- BALDEN** 2. DATE OF DEATH **October 29, 1950**

3. PLACE OF DEATH: a. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE **Maryland** b. COUNTY _____

b. FULL NAME OF HOSPITAL OR INSTITUTION **University Hospital** c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

d. STREET ADDRESS (If rural, give location) **714 Druid Hill Avenue**

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX **Male** 6. COLOR OR RACE **Colored** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **March 6, 1923** 9. AGE (In years last birthday) **27** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Tailor** 11. BIRTHPLACE (State or foreign country) **Mississippi** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

10a. KIND OF BUSINESS OR INDUSTRY **Student** 11. BIRTHPLACE (State or foreign country) **Mississippi** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Emmett Clyde Balden Bolden** 14. MOTHER'S MAIDEN NAME **Mary Watson**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **Yes** 16. SOCIAL SECURITY NO. **W. W. II** 17. INFORMANT **Alice Balden (wife)** ADDRESS **311 Carnel St., Durham, N.C.**

18. **E982X** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Internal hemorrhage**
DUE TO **stab wounds of chest and back**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO _____
(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIB-UTING ☐ CAUSE OF DEATH. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) **home** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **513 N. Pace Street**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **October 29, 1950 5:15 A.m.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **Sharp instrument--ice pick**

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE **Stanley B. DeLoach M.D.** 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED **10-30-50**

24A. BURIAL, CREMA-TION, REMOVAL (Specify) **Burial** 24B. DATE **11-2-50** 24C. NAME OF CEMETERY OR CREMATORY **Beechwood, N.C.** 24D. LOCATION (City, town, or county) (State) **Durham NC**

DATE RECEIVED BY LOCAL REGISTRAR **OCT 31 1950** REGISTRAR'S SIGNATURE **W. W. II** 25. FUNERAL DIRECTOR **Scarbrough + Horgett** ADDRESS **Durham NC**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9322
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

ELNA COOK

2. DATE
OF
DEATH

October 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution - residence before admission)

A. STATE

B. COUNTY

Maryland

Anne Arundel

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Linthicum Heights

D. STREET ADDRESS (If rural, give location)

308 Maple Road

5200

c. Length of stay in Baltimore

7 1/2 Hrs.

5. SEX

F

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Nov. 4, 1887

9. AGE (in years
last birthday)

62

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR
INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Flint Hill, Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Taylor Fillmore

14. MOTHER'S MAIDEN NAME

Anna Parr

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Yates Cook, Linthicum Heights, Md.

18.

451X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Dissecting Aneurysm of Aorta

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE. (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular Disease 10 years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 29, 1950, to Oct. 29, 1950, that I last saw the
deceased alive on Oct. 29, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Robert T. Barber

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

10-29-1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 1, 1950

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Brooklyn R.F.D.

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

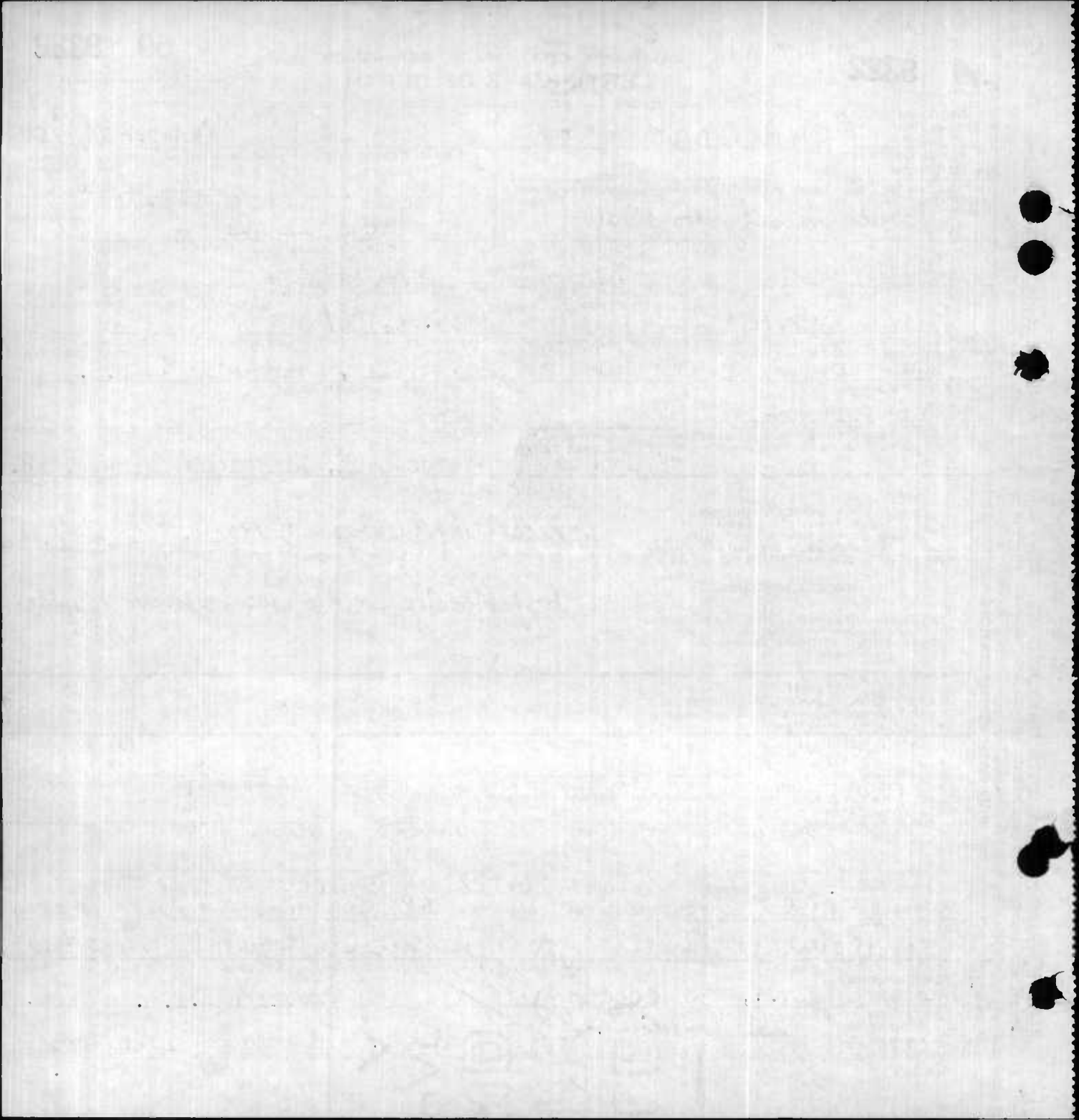
Thomas W. Singleton

Glen Burnie

Md.

VS 150

030d



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9323**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSIAH H. FREEMAN

2. DATE OF DEATH

10/30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE **Md.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

6128 MacBeth Drive

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6128 MacBeth Drive

C. Length of stay in Baltimore

20 Yrs

Yrs.
Mos.
Days

5. SEX
M

6. COLOR OR RACE
W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH
May 1, 1897

9. AGE (in years, last birthday)
53

If Under 1 Year Months Days
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician

10B. KIND OF BUSINESS OR INDUSTRY
Navy Yd. (retired)

11. BIRTHPLACE (State or foreign country)
Georgia

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

LeRoy Freeman

14. MOTHER'S MAIDEN NAME

Gertrude Haralson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW1

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Gertrude S. Habercam 6128 MacBeth Drive

18. **151X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Carcinoma of Stomach and Liver.

5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Exhaustion

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1947

19B. MAJOR FINDINGS OF OPERATION

adenocarcinoma

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 15, 1950**, to **Oct. 30, 1950**, that I last saw the deceased alive on **Oct. 30, 1950**, and that death occurred at **m.**, from the causes and on the date stated above.

23A. SIGNATURE

John H. C. Blake

M. D.

23B. ADDRESS

Med. Arts Bldg

23C. DATE SIGNED

10-31-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county) (State)

Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams

25. FUNERAL DIRECTOR

Charles H. Gandy & Son Inc

ADDRESS

118 W. Mt. Royal Ave. 0466

9822 06

3



S-361
50 9324BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9324

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles Dietrich Struve

2. DATE
OF
DEATH

Oct. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

428 N. Lakewood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md

Baltimore

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

428 N. Lakewood

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 15

9. AGE (In years,
last birthday)

76

If Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

U.S. Customs Inspector

10B. KIND OF BUSINESS OR
INDUSTRY

Government

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

American

13. FATHER'S NAME

Andrew Struve

14. MOTHER'S MAIDEN NAME

Elizabeth Meyers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral thrombosis

3 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic cardiovascular
disease

10 years

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

none

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 29, 1949, to Oct. 29, 1950, that I last saw the
deceased alive on Oct. 28, 1950, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Norman B. Hurwitz

M. D.

23B. ADDRESS

3048 W. North Ave.

23C. DATE SIGNED

Oct. 30, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov 1

24C. NAME OF CEMETERY OR CREMATORY

Landon Park Cem

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

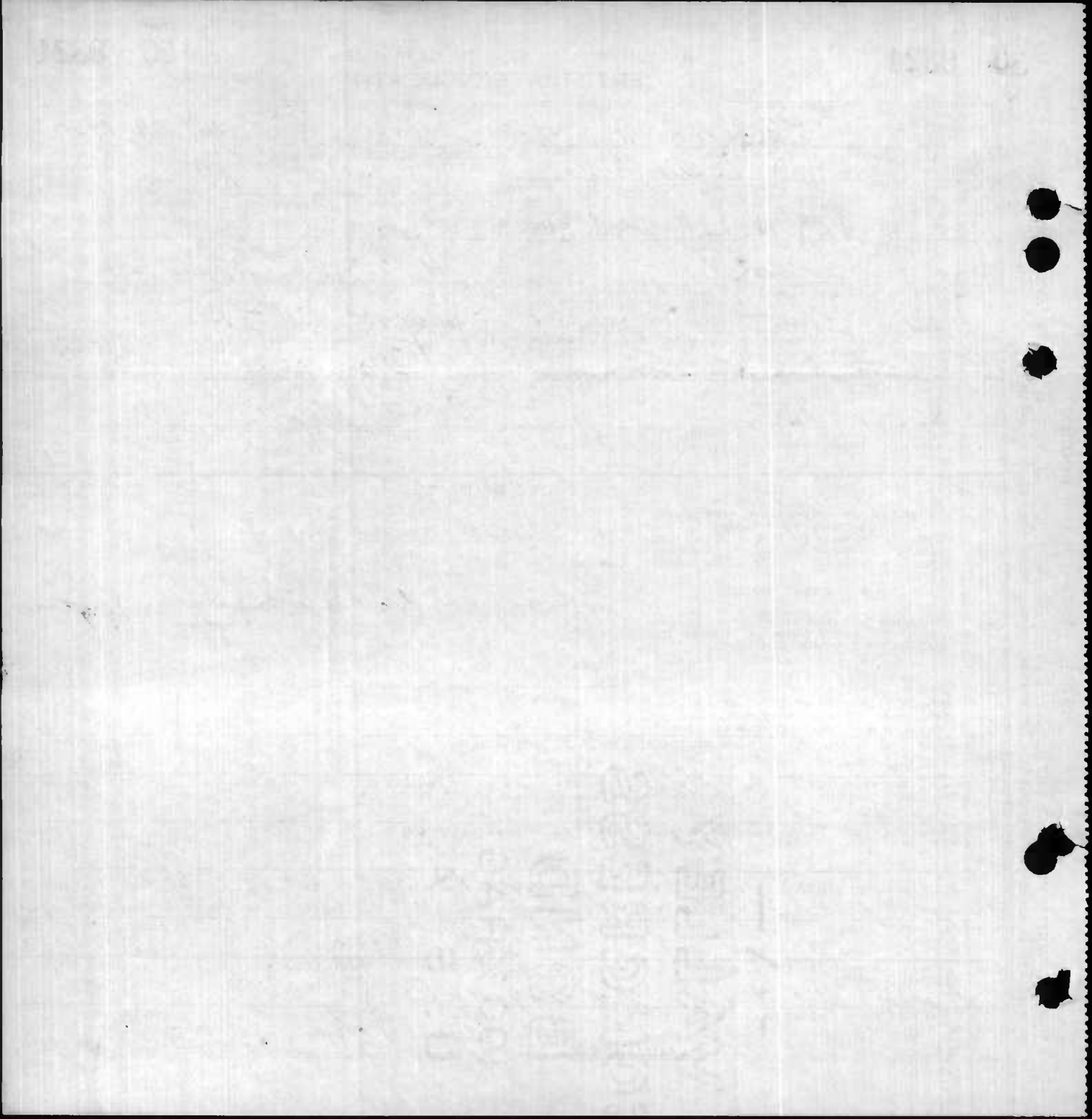
William H. Williams

25. FUNERAL DIRECTOR

Ulbrich Funeral Home

ADDRESS

2006 American Dr



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9325

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

CONNOR, JAMES

2. DATE
OF
DEATH

Oct. 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland, Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Church Home of Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

501 Fairview Ave. 5200

c. Length of stay in Baltimore

53 yrs.

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/27/1897

9. AGE (In years
last birthday)

53

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.12. CITIZEN OF
WHAT COUNTRY?

USA

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR
INDUSTRY

Ice Cream Co.

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

Martin Connor

14. MOTHER'S MAIDEN NAME

Sarah Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

In Main Conn. 501 Fairview Ave.

18. 443X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular
Disease

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

8 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Cardiac Asthma

2 weeks

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

22. I hereby certify that I attended the deceased from 10/7, 1950, to 10/30, 1950, that I last saw the deceased alive on 10/30, 1950, and that death occurred at 10:25 P.M., from the causes and on the date stated above.

23A. SIGNATURE

W. Reed Carroll

M. D.

23B. ADDRESS

Church Home of Hospital

23C. DATE SIGNED

10/30/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Nov 3/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Bald Co

DATE RECEIVED BY
LOCAL REGISTRAR

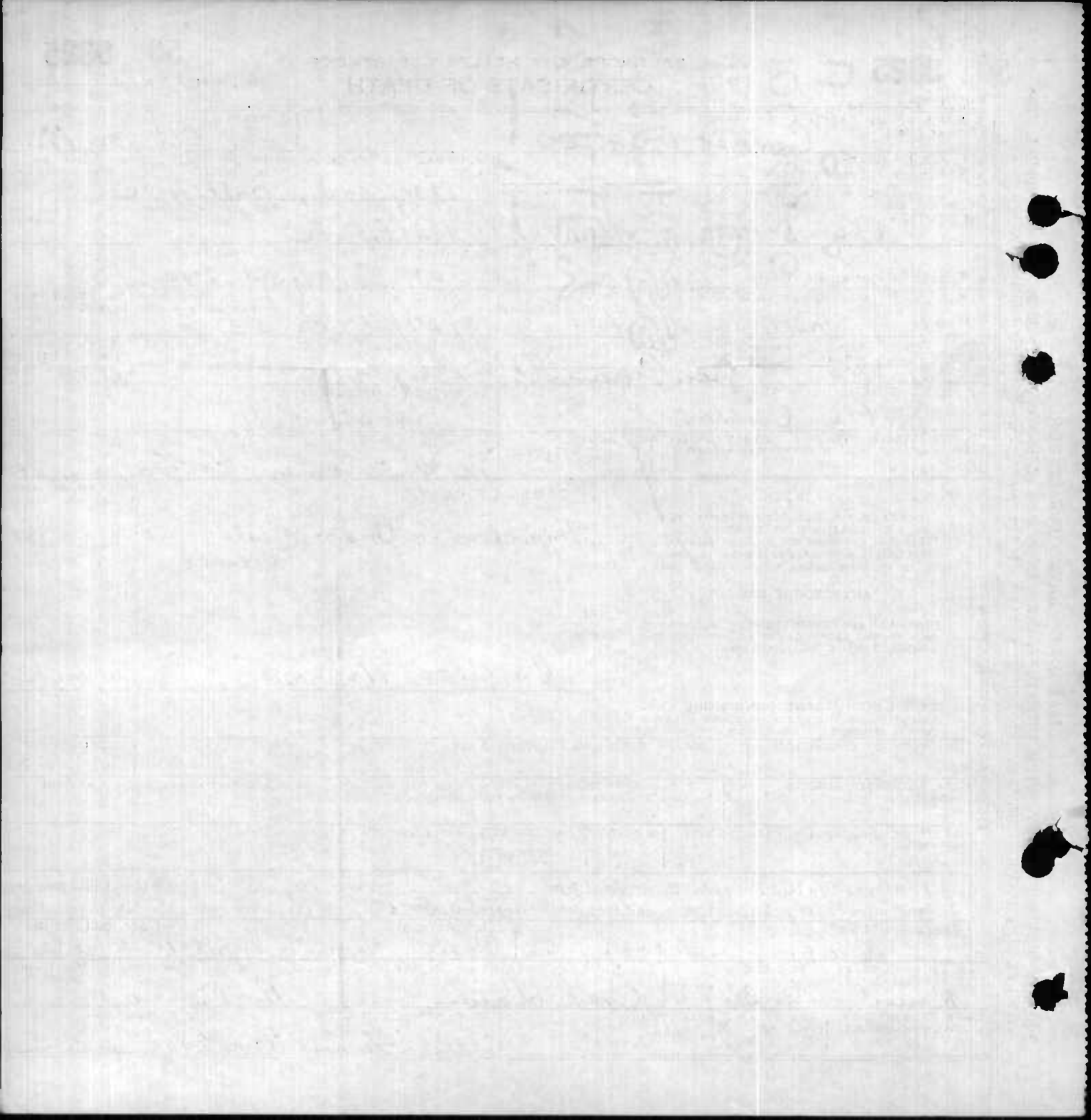
REGISTRAR'S SIGNATURE

OCT 31 1950

25. FUNERAL DIRECTOR

ADDRESS

Willard Funeral Home 2000 Oak



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9326

Registered No.

50 9326

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALFRED EVAN BAILEY

2. DATE
OF
DEATH

October 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Lutheran Hospital (D.J.M.)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

721 Denison Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug. 3, 1890

9. AGE (In years
last birthday)

60

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Electrician

10B. KIND OF BUSINESS OR
INDUSTRY

Dough-Nut Mfg.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Alfred Bailey

14. MOTHER'S MAIDEN NAME

Susan Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr. G. Roger Bailey

ADDRESS
Catonville, Md.
35 Dumore Rd.

18. E976X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bullet wound of head

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

721 Denison Street

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

October 30, 1950

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☒
WORK AT WORK

21F. HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an partial autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. Hootch

23B. CHIEF MEDICAL EXAMINER.....
M.D. ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct. 30, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

Wm. H. Hootch, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tichenor & Son Balto

ADDRESS

VS 151

N 853.4

515-44

164 C

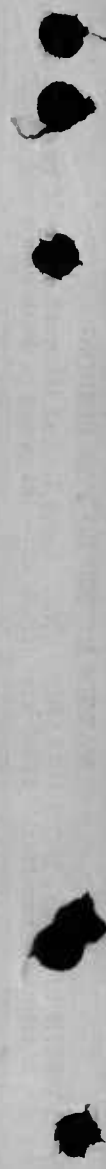
11/2/50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1958

1958



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9327
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERTHAM COPSEY

2. DATE
OF
DEATH

10-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
Md.

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

UNION MEMORIAL HOSP

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2801 St. Paul St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
single

8. DATE OF BIRTH

Sept. 14, 1891

9. AGE (In years
last birthday)

59

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR
INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James L. Copsey

14. MOTHER'S MAIDEN NAME

Zora Anna Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr. James E. Copsey - Charles Co., Md.

ADDRESS

Benedict P. O.

18. E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Fracture of skull

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Roland Ave. & University Parkway

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Oct 28, 1950

m.

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by automobile

22. I certify that I took charge of the remains described above, held an Inspection and inquest and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Durlacher

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct. 29, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/1/50

24C. NAME OF CEMETERY OR CREMATORY

Oldfield Ch. Cem.

24D. LOCATION (City, town, or county)

Hughesville, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Dickner & Son, Balt.

ADDRESS

V S 151

N 803.2

39093

170 c

MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PRINTED, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7800

00

BALTIMORE CITY HEALTH DEPARTMENT
DEATH CERTIFICATE

7800

00



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9328
Registered No. _____

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ISABEL VIRGINIA CADDEN

2. DATE
OF DEATH
Oct. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Home for the Aged of the
Methodist Church
2211 W. Rogers Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2211 W. Rogers Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Sept. 16, 1870

9. AGE (In years
last birthday)

80

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Rev. James R. Cadden

14. MOTHER'S MAIDEN NAME

Isabel Bouldin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

ADDRESS Ave.

Miss Miriam O. Coates - 2211 W. Rogers

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Myocardial Insufficiency

12 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

10 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct-16, 1950, to October 29, 1950, that I last saw the
deceased alive on 10-29, 1950, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Arthur J. Davies

M. D.

23B. ADDRESS

800 W 32nd St.

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/1/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 31 1950

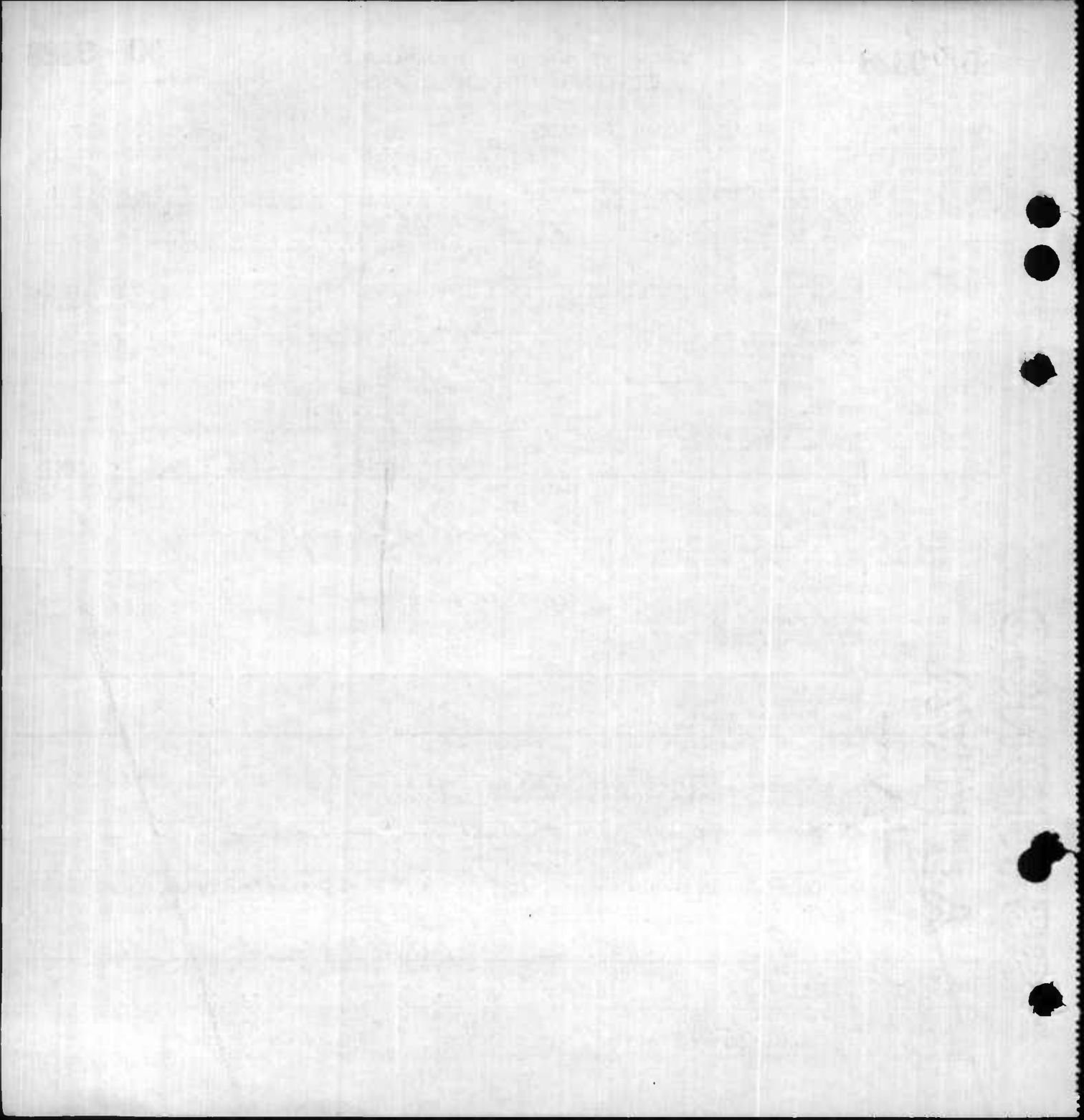
REGISTRAR'S SIGNATURE

Wm. J. Dickner

25. FUNERAL DIRECTOR

Wm. J. Dickner & Sons - Balto

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Mary Catherine Shea*2. DATE
OF
DEATH*Oct. 27-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION*609 Montpelier St.*

C. CITY OR TOWN (If outside corporate limits, give R.R. and give township)

Maryland Baltimore

D. STREET ADDRESS (If rural, give location)

609 Montpelier St.

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years;
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

*Mr. Joseph R. Shea, 609 Montpelier*18. *422.1*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO*Cerebral Hemorrhage**2 hrs.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO*Arteriosclerotic Cardiovascular
Disease**15 yrs.*

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from *Jan.*, 19*48*, to *Oct.*, 19*50*, that I last saw the
deceased alive on *Apr.*, 19*50*, and that death occurred at *6 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*D. T. Battaglia**5825 Belair Rd**10/30/50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*OCT 31 1950**William M. ...**J. Luck - 5305 Hayford Rd**(D. T. Battaglia)**093d*

Dr. D. B. Baker
5879 Baker

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9330

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

3001 Batarea Ave.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

July 8 - 1876

9. AGE (In years,
last birthday)

74

10. Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work during most of working life, even if retired)

Retired Maintenance

10B. KIND OF BUSINESS OR
INDUSTRY

B.T.C.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Peter J. Curran

14. MOTHER'S MAIDEN NAME

Clara Ruff

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-10-3034

17. INFORMANT

Mrs Ralph Bohme - 2310 Hamilton

ADDRESS

18. 42011

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Chronic Myocarditis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Emphysema

General Arterio Sclerosis

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

None

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

None

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 30, 1950, to Oct 30, 1950, that I last saw the deceased alive on Oct 30, 1950, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

L. K. Hardy M.D.

23B. ADDRESS

5706 Harford Rd.

23C. DATE SIGNED

10-31-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

OCT 31 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. J. Luck

ADDRESS

5305 Harford Rd

Don Gurdy

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9331
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Helen Stromberg

2. DATE
OF
DEATH

Oct. 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

3505 Taney Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3505 Taney Rd.

c. Length of stay in Baltimore

Lifetime

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct. 29, 1875

9. AGE (In years last birthday)

75

11 Under 1 Year

Months: 1 Days

12 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School teacher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George Stromberg

14. MOTHER'S MAIDEN NAME

Sarah Greenbaum

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Florence Stromberg 3505 Taney Rd.

18.

172X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinomatosis

INTERVAL BETWEEN ONSET AND DEATH

1+ yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Adenocarcinoma of uterus

10 years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Hypertension

25 years

Arteriosclerosis, generalized

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from December, 1935, to Oct. 30, 1950 that I last saw the deceased alive on 30 Oct., 1950, and that death occurred at 4 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Nov. 17 50

Baltimore Hebrew

Baltimore

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

OCT 31 1950

Huntington Williams, M.D.

David Sondheim

1902 Eutaw Place

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9332
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ABRAHAM J. RICE

2. DATE OF DEATH

OCT. 31, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3814 NORFOLK AVE.

c. Length of stay in Baltimore

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W

8. DATE OF BIRTH

APRIL 9, 1869

9. AGE (In years last birthday)

81

If Under 1 Year Months Days If Under 24 Hours Hours Min.

6 22

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Retired Signaler

11. BIRTHPLACE (State or foreign country)

ALSACE-LORRAINE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ISAAC RICE

14. MOTHER'S MAIDEN NAME

KALMA FREUDENBERG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL SECURITY NO.

17. INFORMANT

DAUGHTER

ADDRESS

7018 Park Heights Ave.

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

and (B) Hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis, generalized

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from OCT. 23, 1950 to OCT. 31, 1950, that I last saw the deceased alive on OCT. 31, 1950, and that death occurred at 12:22 AM, from the causes and on the date stated above.

23A. SIGNATURE

W. F. Coe

23B. ADDRESS

UNION MEMORIAL HOSPITAL

23C. DATE SIGNED

OCT. 31, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Nov 2-1950 Burial

Balto Hebrew Cem

Belair Rd

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 31 1950

W. F. Coe

J. AHRENS & CO.

Funeral Directors.

VS 150

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



524 50 9333

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9333

Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
			MAMIE E. HENKEL			10/29/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland So. Balto. Hosp.						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF HOSPITAL OR INSTITUTION						A. STATE Md.		
C. Length of stay in Baltimore						B. COUNTY		
5. SEX F						C. CITY OR TOWN Baltimore		
6. COLOR OR RACE W						D. STREET ADDRESS (If rural, give location) 827 Patapsco Avenue		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W						E. AGE (in years last birthday) 55		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework						11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY Home						12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ? England						14. MOTHER'S MAIDEN NAME Anna Slaughter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No						16. SOCIAL SECURITY NO.		
17. INFORMANT Family - Same						ADDRESS		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION (A) DUE TO CORONARY ARTEROSCLEROSIS (B) DUE TO HYPERTENSIVE CARDIO-VASCULAR DISEASE (C)						INTERVAL BETWEEN ONSET AND DEATH 6 days many years many years		
MEDICAL CERTIFICATION								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 10-28, 1950, to 10-29, 1950, that I last saw the deceased alive on 10-28, 1950, and that death occurred at 4:50 a.m., from the causes and on the date stated above.								
23A. SIGNATURE Augustin del Campo			23B. ADDRESS South Balto General Hospital			23C. DATE SIGNED 10-29-50		
24A. BURIAL, CREMATION, REMOVAL (Specify) B			24B. DATE II/1/50			24C. NAME OF CEMETERY OR CREMATORY Meadowridge		
24D. LOCATION (City, town, or county) Baltimore			24E. LOCATION (State) Baltimore					
DATE RECEIVED BY LOCAL REGISTRAR NOV 1 1950			REGISTRAR'S SIGNATURE Huntington Williams, M.D.			25. FUNERAL DIRECTOR James L. ...		
VS 150			130 E. Fort Ave.					

093d

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

August Myers

2. DATE
OF
DEATH

10/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

Lutheran Hosp. of Md.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 24-03

D. STREET ADDRESS (If rural, give location)

1437 Battery Ave #30

c. Length of stay in Baltimore

34

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

April 13, 1891

9. AGE (In years last birthday)

59

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Balti. Transit Co. Motorman

10B. KIND OF BUSINESS OR INDUSTRY

Transit Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry J. Myers

14. MOTHER'S MAIDEN NAME

Ellen Elizabeth Wade

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-10-0688

17. INFORMANT

ADDRESS

Kenneth Myers. 1437 Battery Ave.

18. *451 X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Ruptured aneurysm of abd. aorta*

3 days?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Arteriosclerosis*

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

None

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/27*, 19*50*, to *10/29*, 19*50*, that I last saw the deceased alive on *10/29*, 19*50*, and that death occurred at *220 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Joseph D. Lichtenberg

M. D.

23B. ADDRESS

Lutheran Hosp. of Md.

23C. DATE SIGNED

10/29/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

11/1/50

24C. NAME OF CEMETERY OR CREMATORY

GLEN HAVEN

24D. LOCATION (City, town, or county)

RITCHIE HIGHWAY

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC 715 LIGHT ST.

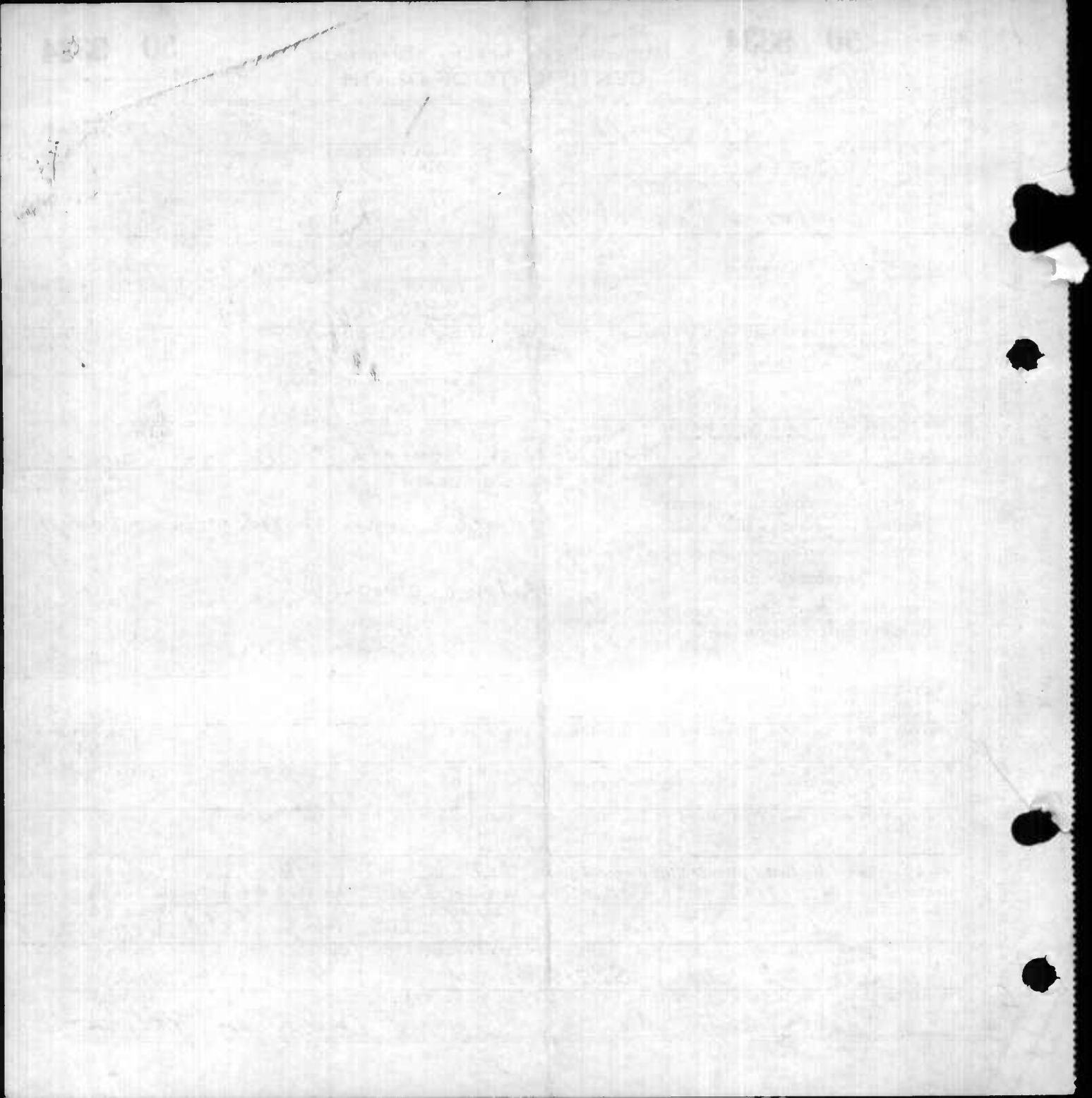
NOV 1 1950

661 51

096.0 -30

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



V-300

50 9335

BALTIMORE CITY HEALTH DEPARTMENT

50 9335

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Mary Vito
Marie Vito2. DATE
OF
DEATH

Oct. 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

St. Joseph's Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give
township)

D. STREET ADDRESS (If rural, give location)

627 N. Duncan Street

c. Length of stay in Baltimore

55yr.

5. SEX

Fe.

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

May 18/1873

9. AGE (In years
last birthday)

77

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

- Eversa

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

(If yes, give war or dates of service)

none

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Mrs Marie Vito

ADDRESS

627 N. Duncan St

18. 260X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral hemorrhage
DUE TO arteriosclerosis
(B) Diabetes mellitus
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Empyema, left

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 9/6/1950, to 10/31/1950, that I last saw the
deceased alive on 10/31/1950, and that death occurred at 9:25 AM, from the causes and on the date stated above.

23A. SIGNATURE

Thaddeus Siwinski

M. D.

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

10/31/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/3/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 1 1950

REGISTRAR'S SIGNATURE

Tunington Williams, Jr.

25. FUNERAL DIRECTOR

Philip Herwig Sons Orleans St

ADDRESS

2024

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly.
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death early and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9336

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Rosalie B. Paige Hamilton

2. DATE
OF
DEATH

Oct 30th 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Baltimore City

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

502 Somerset Rd

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

2-7-14

C. Length of stay in Baltimore

Eighteen

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

502 Somerset Road

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Feb. 14th 1899

9. AGE (In years,
last birthday)

59

10 Under 1 Year

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Domestic Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wm. B. Paige

14. MOTHER'S MAIDEN NAME

Rosalie H. Paige Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Douglas G. Loeble, Garrison Md

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary occlusion

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Ungradual Straining

1 Year

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from Jan. 1949 to Oct 31st, 1950, that I last saw the
deceased alive on Oct 15, 1950, and that death occurred at 12:15 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 1 1950

Huntington Williams, M.D.

Henry W. Perkins & Sons Co 492 York Rd

1000

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) *Mrs. Agnes Dew*

2. DATE OF DEATH *10-31-50* *S.A.M.*
Where deceased lived. If institution: residence before admission)

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore, Md.*

4. USUAL RESIDENCE (If rural, give location)
A. STATE *Md* B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION
St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, Md. *7-01*

C. Length of stay in Baltimore *40*

D. STREET ADDRESS (If rural, give location)
Withers Ave 2901 E. Monument St

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

May 30 1896 *54*

9. AGE (in years last birthday) If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor

10B. KIND OF BUSINESS OR INDUSTRY
Vet. Administration

11. BIRTH PLACE (State or foreign country)
Williamsport, Pa

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME

Edward H. Miller

14. MOTHER'S MAIDEN NAME

Emma Metzger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Hosp. Record

18. *157X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Acute Congestive Heart Failure* *3 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Adeno - Carcinoma, head of Pancreas* *6 months*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
10-17-50

19B. MAJOR FINDINGS OF OPERATION
Adeno - Carcinoma of Pancreas

20. AUTOPSY?
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/8* 1950 to *10/31* 1950 that I last saw the deceased alive on *10/30* 1950 and that death occurred at *5th* m., from the causes and on the date stated above.

23A. SIGNATURE

Stephen K. Padurnis

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

10/31/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov 3 1950

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county) (State)

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

NOV 1 1950

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR, ADDRESS

Henry J. Jenkins, Sons & 4905 York Rd

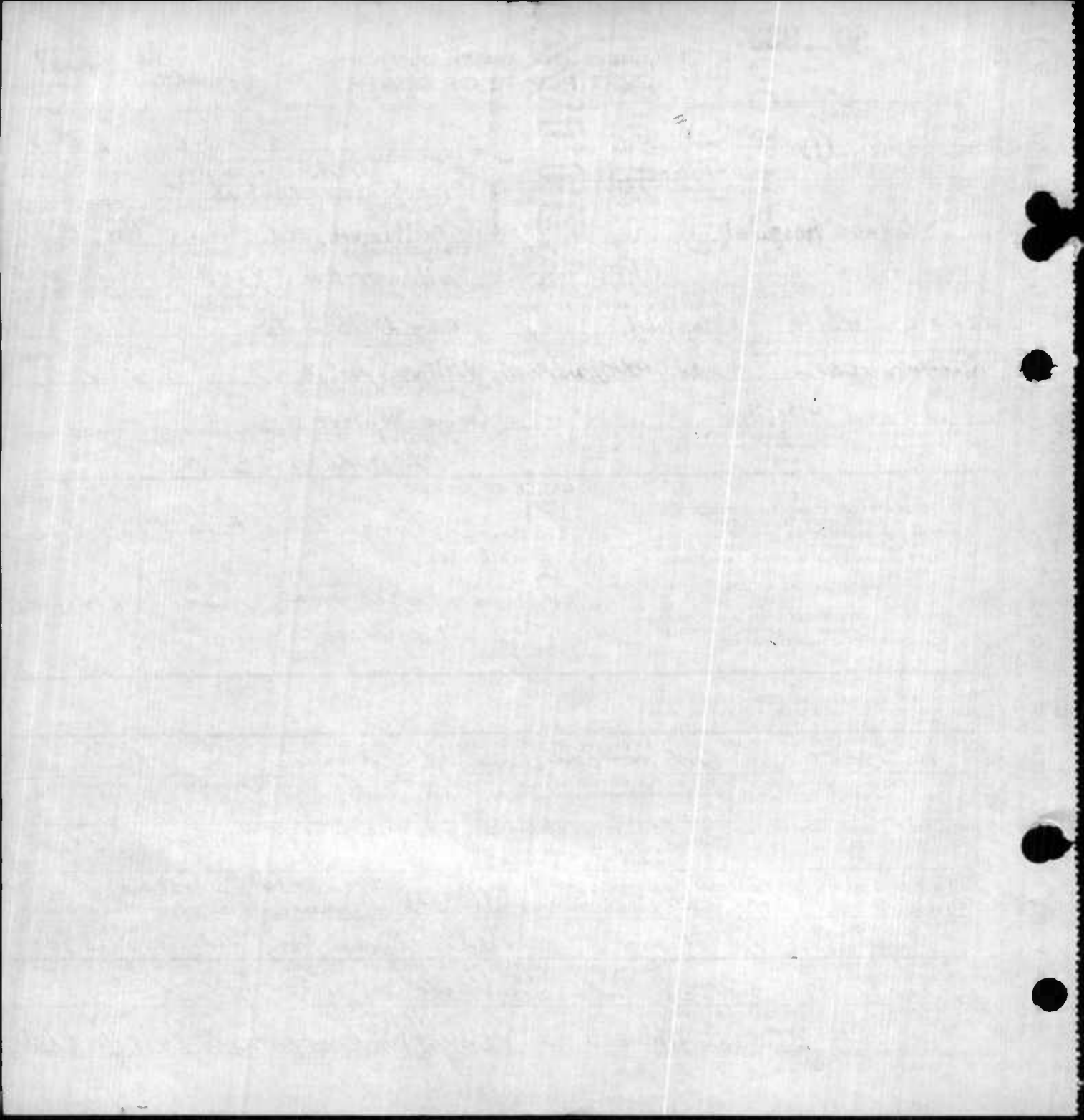
VS 150

290 91

0419

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)*Jennie F. Cavey*2. DATE OF DEATH *Mon. Oct. 30, 1950*3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE *md.* B. COUNTY _____B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION*2522 W. Franklin St.*C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
*Baltimore 23-02*C. Length of stay in Baltimore *33* Yrs. *Mon.* Days *None*D. STREET ADDRESS (If rural, give location)
1612 Olive St.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

B. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

*Female**White**Widowed**Nov. 13, 1862**87**- - -**- - -*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY

*Housewife -**at home**Howard Co., Ind.**U.S.A.*

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

*Jesse Redmond**Elizabeth (P.)*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*No**None**Ernest J. Cavey (son) 1612 Olive St.*18. *491 X 1*

CAUSE OF DEATH

*(30)*DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Broncho pneumonia**2 weeks*

ANTECEDENT CAUSES

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST,

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.*Arteriosclerotic Heart Disease**Years*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from *Sept 1, 1950* to *Oct 30, 1950* that I last saw the deceased alive on *Oct 30, 1950* and that death occurred at *8:30 p.m.* from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

S. Meedelis

M. D.

*651 N. Beutalon**10/31/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Nov 1 1950**Wm. H. Williams, Jr.**A. Howard Evans**093d**1400 S. Charles St. - Balt - 30 Md.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

B-650
REA-142496

50 9339

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9339

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) George M. Brown

2. DATE
OF
DEATH

Oct. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION Baltimore City Hospitals

4940 Eastern Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

17-02

D. STREET ADDRESS (If rural, give location)

1302 Division Street

c. Length of stay in Baltimore

9 years

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 31, 1885

9. AGE (In years
last birthday)

65

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

MINISTER

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Eliza ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Uremia

DUE TO

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Gangrene of Right Leg

DUE TO

2 weeks

(C) Hypertensive Cardiovascular Disease

2 Years

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 10-13, 1950, to 10-29, 1950, that I last saw the
deceased alive on 10-29, 1950 and that death occurred at 6:40 P. M., from the causes and on the date stated above.

23A. SIGNATURE

G. J. Rogers M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Shipped 11/3/50

Florence S. C.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 1 1950

Huntington Williams, M.D.

A. Halstead - 918-

✓

11/11/11
11/11/11
11/11/11

LVC
140450

50 9340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9340

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Leo Frances Mooney

2. DATE
OF
DEATH

Oct. 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)Baltimore City Hospitals
4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

522 Tolna Street

c. Length of stay in Baltimore

8 Yrs.

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Feb 2, 1893

9. AGE (in years
last birthday)

57

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

ELECTRICIAN

10B. KIND OF BUSINESS OR
INDUSTRY

TELEPHONE CO

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Mooney

14. MOTHER'S MAIDEN NAME

Catherine Gibbons

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT
Records* BCH 4940 Eastern Avenue

ADDRESS

18.

162X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchogenic Carcinoma

INTERVAL BETWEEN
ONSET AND DEATH

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Carcinomatosis

Unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-20-50

19B. MAJOR FINDINGS OF OPERATION

Biopsy liver

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 7, 1950 to Oct. 31, 1950, that I last saw the
deceased alive on Oct. 31, 1950, and that death occurred at 12:25 PM, from the causes and on the date stated above.

23A. SIGNATURE

J. B. Boyer M. O.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

11-1-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)Burial
DATE RECEIVED BY
LOCAL REGISTRAR

24B. DATE

Nov. 3-1950

24C. NAME OF CEMETERY OR CREMATORY

St. Gabriels Cem.

24D. LOCATION (City, town, or county)

Hazelton Pa.

(State)

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John A. Mann

ADDRESS

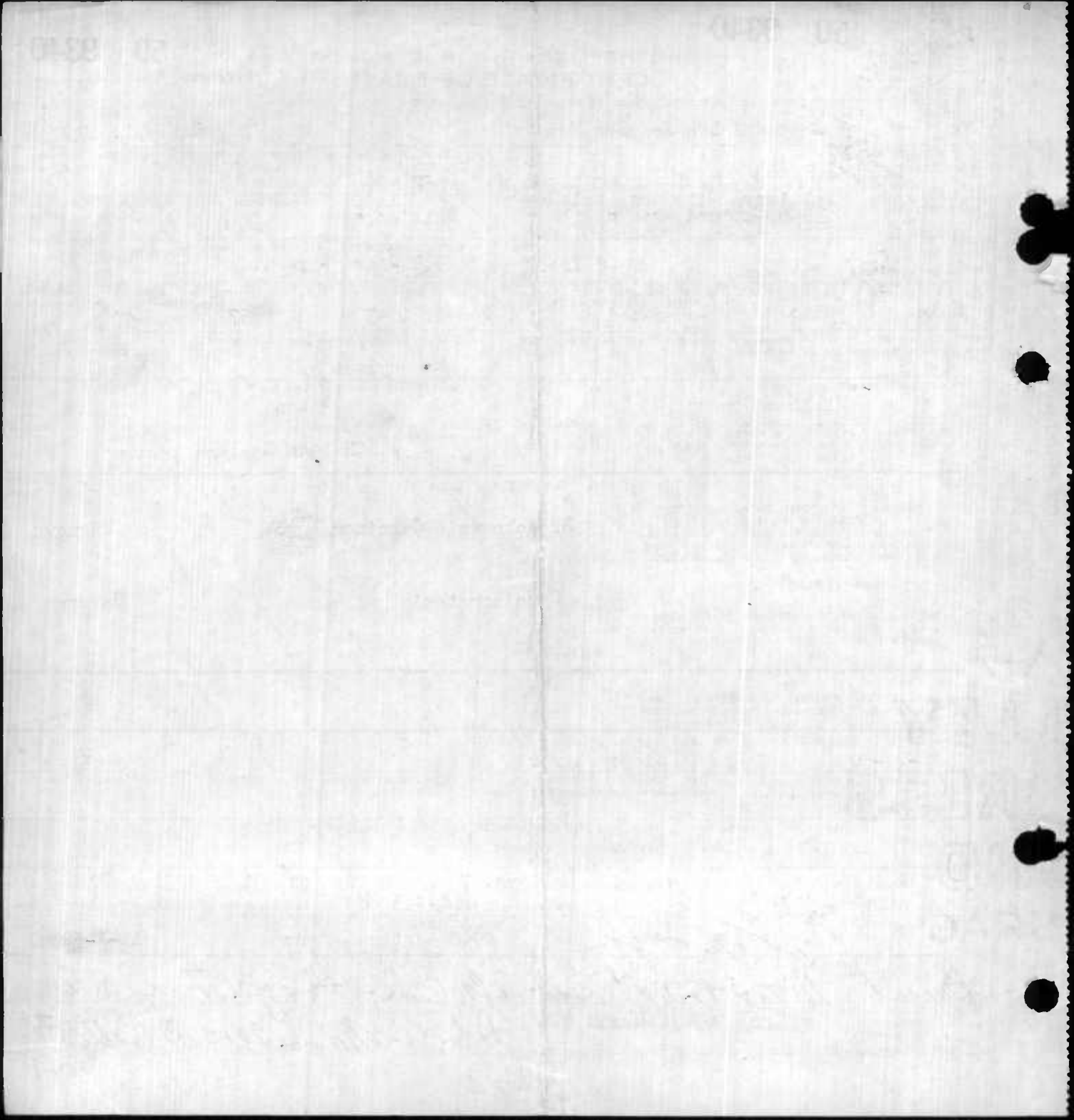
3000 E. Balto St.

VS 150

515-5A

047c

(24)



50 9341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9341

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH

BRADY

2. DATE
OF
DEATH

Oct. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

S. Balt. General Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Balto.

24-01

township)

D. STREET ADDRESS (If rural, give location)

1448 Reynold St

c. Length of stay in Baltimore

37 yrs.

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Jan 6

9. AGE (In years

last birthday)

73

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Harrisburg, Pa

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Thomas Baker

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Charles Brady 1448 Reynold

18. 223 X, E900.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral hemorrhage and fracture of skull

DUE TO acoustic neurinoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☒ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)

1448 Reynold St.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Oct. 28, 1950 8:15 Pm.

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down front steps

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Duclache

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☐

23C. DATE SIGNED

Oct. 29, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/1/50

24C. NAME OF CEMETERY OR CREMATORY

Balto. National Cem. Balto. Md.

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 1 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Chas. F. Dill 1501 E. Fort Ave.

ADDRESS

V S 151

567

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information could be carried by the
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CLINICAL CASE ON DEATH

CLINICAL CASE ON DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 9342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9342
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Viviani

2. DATE
OF
DEATH

October 31, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 211 W. Franklin

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore Md. 4-01

D. STREET ADDRESS (If rural, give location)

211 W. Franklin St.

c. Length of stay in Baltimore

9

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

Apr. 9, 1885

9. AGE (In years last birthday)

65

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR INDUSTRY

Schloss Bros. Clothing Industry

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Roco Viviani

14. MOTHER'S MAIDEN NAME

Antonette Galido

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

221-09-4636

17. INFORMANT

ADDRESS

Mrs. Bella Viviani 211 W. Franklin

18. 163X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Lung (left)

INTERVAL BETWEEN ONSET AND DEATH

Unknown

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug. 10, 1950, to Oct. 31, 1950, that I last saw the deceased alive on Oct. 31, 1950, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Philbert Artigiani M.D.

23B. ADDRESS

2942 E. Fayette St.

23C. DATE SIGNED

Nov. 1/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 4, 50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Wilmington Del.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 1 1950

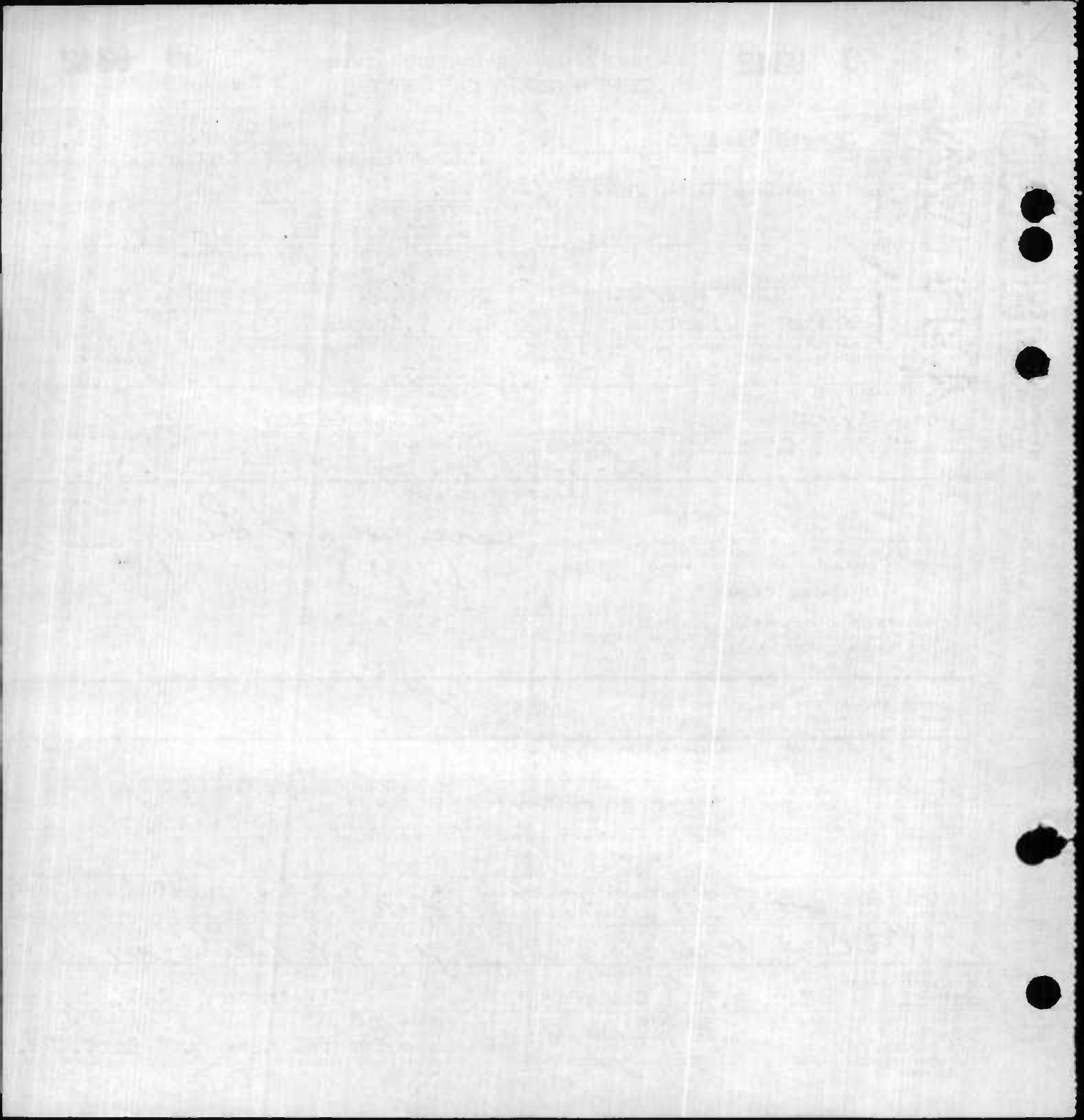
REGISTRAR'S SIGNATURE

Antington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Heemann Funeral Home 6067 Harf. Rd.



50 9343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9343
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY E. CLARK EBRON

2. DATE OF DEATH
Oct. 31, 19503. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

25 N. Bond St.

6-05

c. Length of stay in Baltimore

18 yrs.

5. SEX

Female Colored

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

April 11, 1928

9. AGE (In years last birthday)

22

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greenville N.C.

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

York Clark

14. MOTHER'S MAIDEN NAME

Clara Chapman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Clara Clark 509 Fulton Ave.

18. 490x and 650.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Abortion (recent)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: Natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

RS Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED
Oct. 31, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov 2, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Ceme

24D. LOCATION (City, town, or county)

A.A. County Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Mis. Robert G. Elliott & Daughter

VS 151

141 d

1129 N. Caroline

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information could be easily applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

318

318

REPUBLIC CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Marital Status		Occupation	
John Doe		45		Male		White		Married		Teacher	
Date of Death		Place of Death		Cause of Death		Died at Home		Buried at		Buried in	
Jan 15, 1920		New York City		Heart Disease		Yes		Catholics		St. Mary's	
Physician		Medical Examiner		Coroner		Registrar		Burial Officer		Witness	
Dr. Smith		J. Brown		W. Green		M. White		C. Black		T. Grey	

Name of Deceased		Age		Sex		Race		Marital Status		Occupation	
John Doe		45		Male		White		Married		Teacher	
Date of Death		Place of Death		Cause of Death		Died at Home		Buried at		Buried in	
Jan 15, 1920		New York City		Heart Disease		Yes		Catholics		St. Mary's	
Physician		Medical Examiner		Coroner		Registrar		Burial Officer		Witness	
Dr. Smith		J. Brown		W. Green		M. White		C. Black		T. Grey	

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9344

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Angelina Bianca

2. DATE
OF
DEATH

Oct. 28 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1316 Edison Highway

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Md.

B. COUNTY

5. FULL NAME OF
HOSPITAL OR
INSTITUTION
(If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1316 Edison Highway

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

May 23 1887

9. AGE (In years
last birthday)

63

If Under 1 Year

Months Days

5 5

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Cefalu Italy

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Vincenzo Cicero

14. MOTHER'S MAIDEN NAME

Concetta Maranto

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Giovannina Mancuso 2712 E. Preston St.

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

3 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Jan. 1 - 5 - 1948 to 10 - 28, 1950 that I last saw the
deceased alive on 10 - 28, 1950, and that death occurred at 5 - m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Nov. 2nd/50

Holy Redeemer Cemetery 4430 Belair Rd. Balt. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

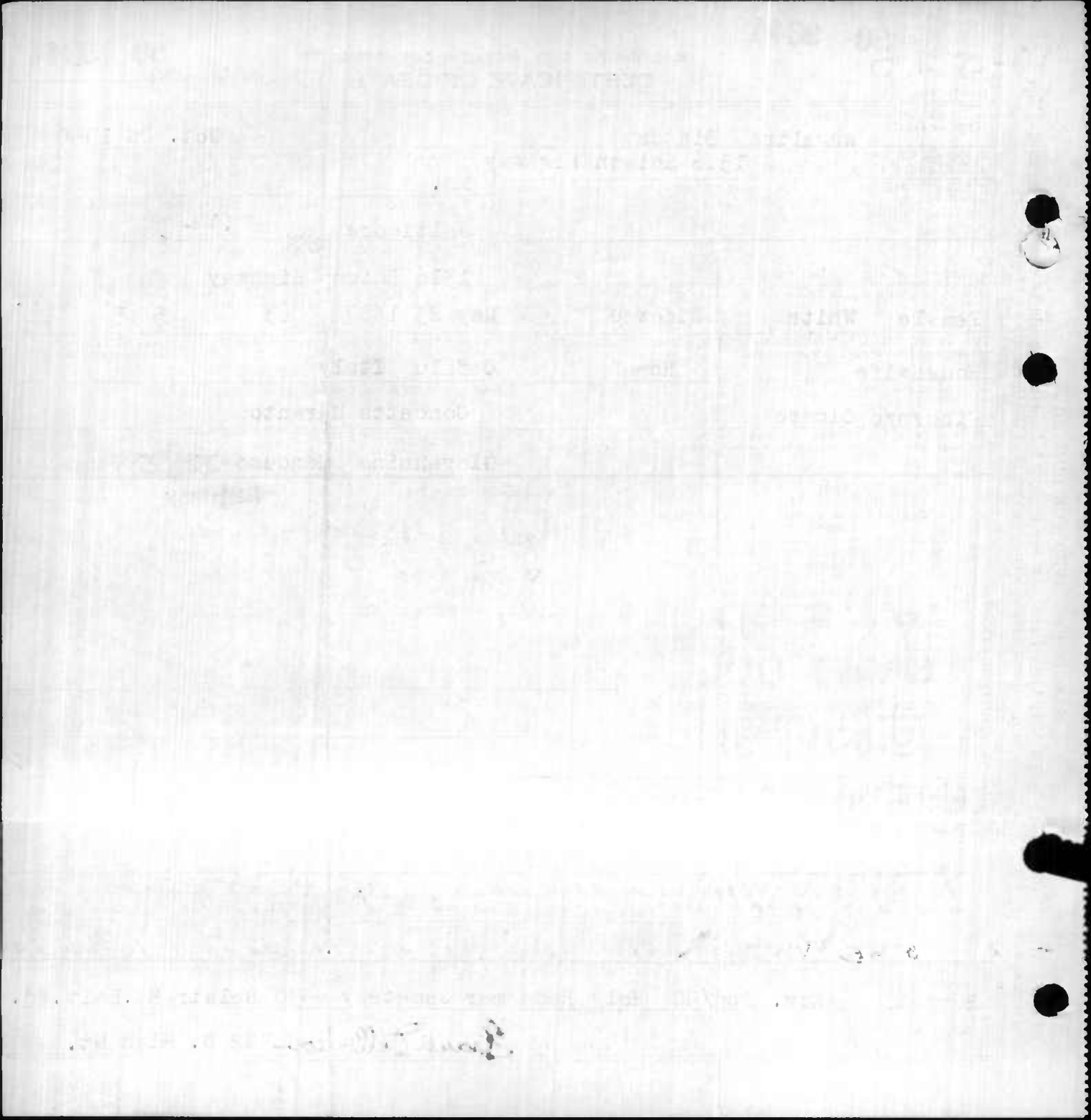
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 1 1950

Frank Della Lora 322 S. High St.



CERTIFICATE CORRECTED

11-1-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9345
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE H. B. KAHL

2. DATE
OF
DEATH

10/30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
Md.

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

3009 Ridgewood Ave.,

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

Sept. 27, 1875

9. AGE (In years
last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR
INDUSTRY

Barber Shop Owner

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Justis Kahl

14. MOTHER'S MAIDEN NAME

Sophia Fredericks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Morris R. Kahl, 3009 Ridgewood Ave.

18.

600.0

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

UREMIA

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

NEPHROSCLEROSIS

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CHRONIC PYELOIDEPHRITIS

BENIGN HYPERTROPHY OF PROSTATE

INTERVAL BETWEEN
ONSET AND DEATH

Weeks

Years

"

"

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/3, 1950, to 10/20, 1950, that I last saw the
deceased alive on 10/29, 1950, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. Albert E. Baker

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

10/30/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11/1/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

L. William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

B. Vernon Lemmon, 4611 Park Heights Ave.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

131 a

John Justice Rd
Sophie Fredericks

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50-9346**

BIRTH NO. **50-13225**

1. NAME OF DECEASED (Type or Print) VASHTI E. JONES		2. DATE OF DEATH October 31, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 8		D. STREET ADDRESS (If rural, give location) 2421 S. Paca Street	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH 2/17/1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 8 If Under 1 Year: Months 14 Days
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amest		14. MOTHER'S MAIDEN NAME Naomi Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Lucius Jones 2421 S Paca St	

18. E 921.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Asphyxia (A) aspiration of vomitus DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Malnutrition DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City Hosp. 4940 Eastern Avenue	
21D. TIME (Month) (Day) (Year) (Hour) October 31, 1950 ? P.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Aspiration of vomitus	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE R S Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 10-31-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/1/50		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Balto Md		25. FUNERAL DIRECTOR ADDRESS Chas Florfer 512 (Anne Arundel) Ave			
DATE RECEIVED BY LOCAL REGISTRAR NOV 1 1950		REGISTRAR'S SIGNATURE Thurston Williams, M.D.			

V S 151

N 933.0

195d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

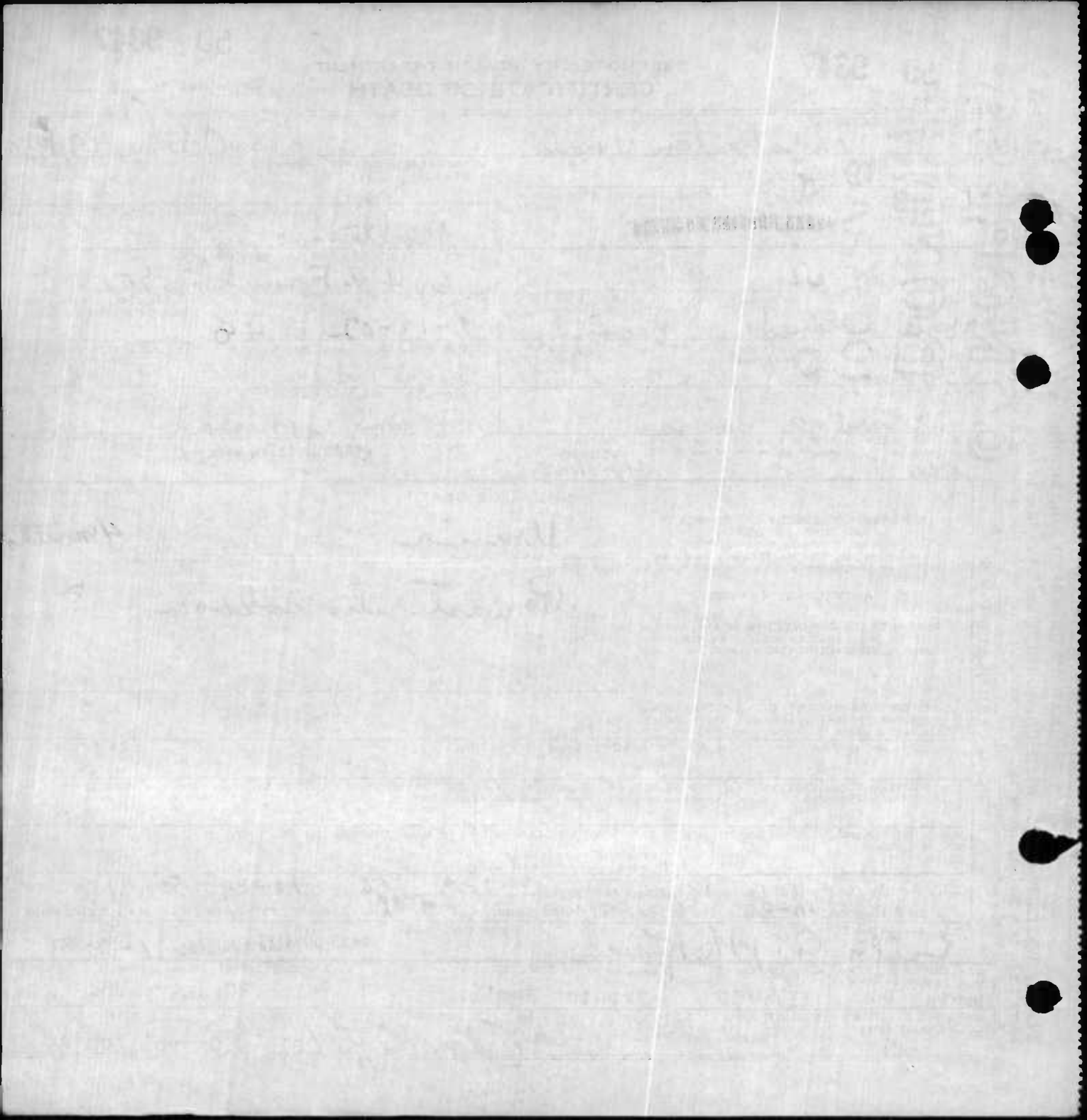
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MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-520 50 9347		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 9347 Registered No. _____	
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) <u>Winchester Jones</u>			2. DATE OF DEATH <u>October 29, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md.</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>33 JONES HOPKINS HOSPITAL</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 17-01</u>		
c. Length of stay in Baltimore <u>Life</u>			D. STREET ADDRESS (If rural, give location) <u>654 W. Franklin St.</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>8-13-02</u>	9. AGE (In years last birthday) <u>48</u>	If Under 1 Year: Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>			11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>Box Company (M)</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Edmund Jones</u>			14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If so, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-01-4528</u>		
17. INFORMANT <u>JOHN DUTMAN</u> ADDRESS _____					
18. <u>456x</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> DUE TO <u>Periarteritis nodosa</u> DUE TO <u>?</u> DUE TO <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-8-1950</u> , to <u>10-29, 1950</u> , that I last saw the deceased alive on <u>10-29, 1950</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Victor A. McQuirk</u> M. D.			23B. ADDRESS <u>JONES HOPKINS HOSPITAL</u>		23C. DATE SIGNED <u>10.30.50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/2/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem'l. Pk. I</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. V. County, Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>NOV 1 1950</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>		25. FUNERAL DIRECTOR <u>San. Starke</u> ADDRESS <u>512 N. Carrollton Av</u>	

3424K

099.0



Dr Kallins 1847 W. North Ave.

W-16 50 9348

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9348
Registered No.

1. NAME OF DECEASED (Type or Print) FRANCES J. WEBER (MRS)		2. DATE OF DEATH OCT 31 50	
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTO		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY 19-02	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1704 W FAYETTE ST		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO 23 MD	
C. Length of stay in Baltimore LIFE Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1704 W Fayette St	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1/16/1879
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY ✓	9. AGE (In years last birthday) 72
13. FATHER'S NAME SAMUEL PHILLIPS		11. BIRTHPLACE (State or foreign country) MD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		12. CITIZEN OF WHAT COUNTRY? US	
16. SOCIAL SECURITY NO. NO		14. MOTHER'S MAIDEN NAME	
17. INFORMANT C Herbert Weber		ADDRESS 1704 W. Fayette St	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive C-V. Disease DUE TO CAUSE OF DEATH Hypertensive C-V. Disease INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1938 , 19 50 , to 10/31 , 19 50 , that I last saw the deceased alive on 10/31 , 19 50 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above.			
23A. SIGNATURE Edward S. Kallins M. D.		23B. ADDRESS 1847 W. North Ave	23C. DATE SIGNED 11/1/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Buried	24B. DATE Oct 2-50	24C. NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery	24D. LOCATION (City, town, or county) (State) Belair Md
DATE RECEIVED BY LOCAL REGISTRAR NOV 1 1950	REGISTRAR'S SIGNATURE George A. Farley	25. FUNERAL DIRECTOR George A. Farley ADDRESS 093d Fulton Ave + Fayette St	

attending Chapman
Rev. Ed. S. Hallins
1847 St. North Ave

C-450
50 9349BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9349
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES A. CULLEN

2. DATE
OF
DEATH

10-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

U. S. MARINE HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 25-31

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

306 S. BEECHFIELD AVE.

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1/27/93

9. AGE (In years
last birthday)

57

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

ENGINEER

10B. KIND OF BUSINESS OR
INDUSTRY

VET. ADMIN.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SIMON CULLEN

14. MOTHER'S MAIDEN NAME

CAROLYN KNOWLES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WORLD WAR I

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Hospital Records

ADDRESS

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) CEREBRAL HEMMORRHAGE

24 Hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) HYPERTENSION AND

1 yr.

DUE TO

(C) ARTERIOSCLEROSIS

YEARS

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on 10-29, 1950, and that death occurred at 1:53 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Andrew O. Fitzmorris

M. D.

23B. ADDRESS

U. S. Marine Hospital

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10-2-50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 1 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

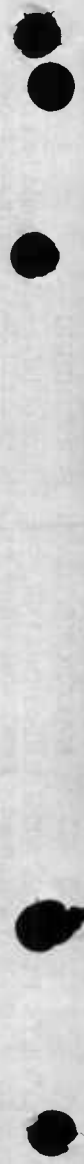
ADDRESS

George A. Farley & Sons, 1111 Fayette St.

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-640

50 9350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9350

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA CARROLL.		2. DATE OF DEATH NOVEMBER 1 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE CITY.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE CITY. B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 2828 Maryland Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE CITY. 12-06		D. STREET ADDRESS (If rural, give location) 2828 MARYLAND AVE.	
c. Length of stay in Baltimore LIFE		Yrs. Mos. Days			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Nov. 12, 1871	9. AGE (In years last birthday) 78	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George W. Schafer		14. MOTHER'S MAIDEN NAME Mary D. Waljen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lena Spilman, 2828, Maryland Avenue	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) APOPLEXY. (A) DUE TO		CAUSE OF DEATH CHRONIC MYOCARDITIS (B) DUE TO ARTERIOR SCLEROSIS. (C)		INTERVAL BETWEEN ONSET AND DEATH OCTOBER 24 1950. 1950 1950 1950	
19A. DATE OF OPERATION NONE		19B. MAJOR FINDINGS OF OPERATION NONE		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from APRIL 2 , 1950 to NOV 1 , 1950, that I last saw the deceased alive on NOV 1 , 1950, and that death occurred at 1.30 AM from the causes and on the date stated above.					
23A. SIGNATURE <i>Chas. J. Clavette</i>		23B. ADDRESS M. D. 3013 ST PAUL STREET.		23C. DATE SIGNED NOV. 1 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 11/3/50		24C. NAME OF CEMETERY OR CREMATORY Louisa Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25. FUNERAL DIRECTOR ADDRESS 24m. Cool, Inc. 1217 St. Paul Street			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Therese J. Williams, M.D.</i>			

NOV 1 1950

131a

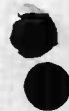
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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9351**BIRTH NO. **50 9351**1. NAME OF DECEASED
(Type or Print)*Sarah Kleinmeyer*2. DATE
OF
DEATH*10-30-50.*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF

HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

St. Agnes Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore 28-41

D. STREET ADDRESS (If rural, give location)

3901 Woodbine Ave (7)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

1-18-1895

9. AGE (In years

last birthday)

55

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

School Teacher

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Christ

14. MOTHER'S MAIDEN NAME

Frances Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Rose M. Kleinmeyer 3901 Woodbine Ave*18. *331X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebrovascular accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/28* 19*50* to *10/30* 19*50*, that I last saw the deceased alive on *10/30* 19*50*, and that death occurred at *7th* P. m., from the causes and on the date stated above.

23A. SIGNATURE

H. H. H. H.

23B. ADDRESS

St. Agnes Hosp

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

11/1/50

24C. NAME OF CEMETERY OR CREMATORY

St. Joseph

24D. LOCATION (City, town, or county)

Johnstown Pa

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

W. H. Cook, Inc. 1217 St. Paul St.

1888

1888

[Faint, illegible handwriting on lined paper, possibly a ledger or account book. The text is mostly illegible due to fading and bleed-through.]

5-120 9352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9352
Registered No.

BIRTH NO. 50-23049

1. NAME OF DECEASED (Type or Print) CASANDRA SUBOCK			2. DATE OF DEATH October 31, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2915 Poplar Terrace			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-47		
D. STREET ADDRESS (If rural, give location) 2915 Poplar Terrace			E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 10/24/50		9. AGE (In years last birthday) 7
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balt. Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George L. Subock			14. MOTHER'S MAIDEN NAME Doris L. Duerling		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Geo. L. Subock 2915 Poplar Terrace		

18. 754.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Congenital heart disease		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		(B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley B. Deanecker M.D.		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Oct. 31, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/50		24C. NAME OF CEMETERY OR CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) Woodlawn Md.		25. FUNERAL DIRECTOR Wm. Bok Inc. 1217 St. Paul St.		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR NOV 1 1950		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	

100-100000

NATIONAL CIVIL SERVICE

CERTIFICATE OF DEATH

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Signature of physician

6. Signature of registrar

7. Signature of informant

8. Signature of witness

9. Signature of funeral director

10. Signature of undertaker

11. Signature of cemetery

12. Signature of burial

13. Signature of interment

14. Signature of cremation

15. Signature of other

16. Signature of record

17. Signature of office

18. Signature of department

19. Signature of state

20. Signature of federal

21. Signature of international

22. Signature of other

23. Signature of record

24. Signature of office

25. Signature of department

26. Signature of state

27. Signature of federal

28. Signature of international

29. Signature of other

30. Signature of record

31. Signature of office

32. Signature of department

33. Signature of state

34. Signature of federal

35. Signature of international

36. Signature of other

37. Signature of record

38. Signature of office

39. Signature of department

40. Signature of state

41. Signature of federal

42. Signature of international

43. Signature of other

44. Signature of record

H-452

50 9353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9353

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

David Helms

2. DATE
OF
DEATH

Oct. 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

H 411 3 W

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

Md

B. COUNTY

before admission)

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 13-02
2205 Eutan Pl

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

10-20-49

9. AGE (In years
last birthday)

If Under 1 Year Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Monroe N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Willie Helms

14. MOTHER'S MAIDEN NAME

Mary F Helms.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 353.3

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Epilepsy

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

1 day

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 10/30/50 to 10/31/50, that I last saw the
deceased alive on 10/31/50, and that death occurred at 2:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas C. McPerson

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10-31-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

Nov. 1-50

24C. NAME OF CEMETERY OR CREMATORY

Monroe N.C.

24D. LOCATION (City, town, or county)

North Carolina

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

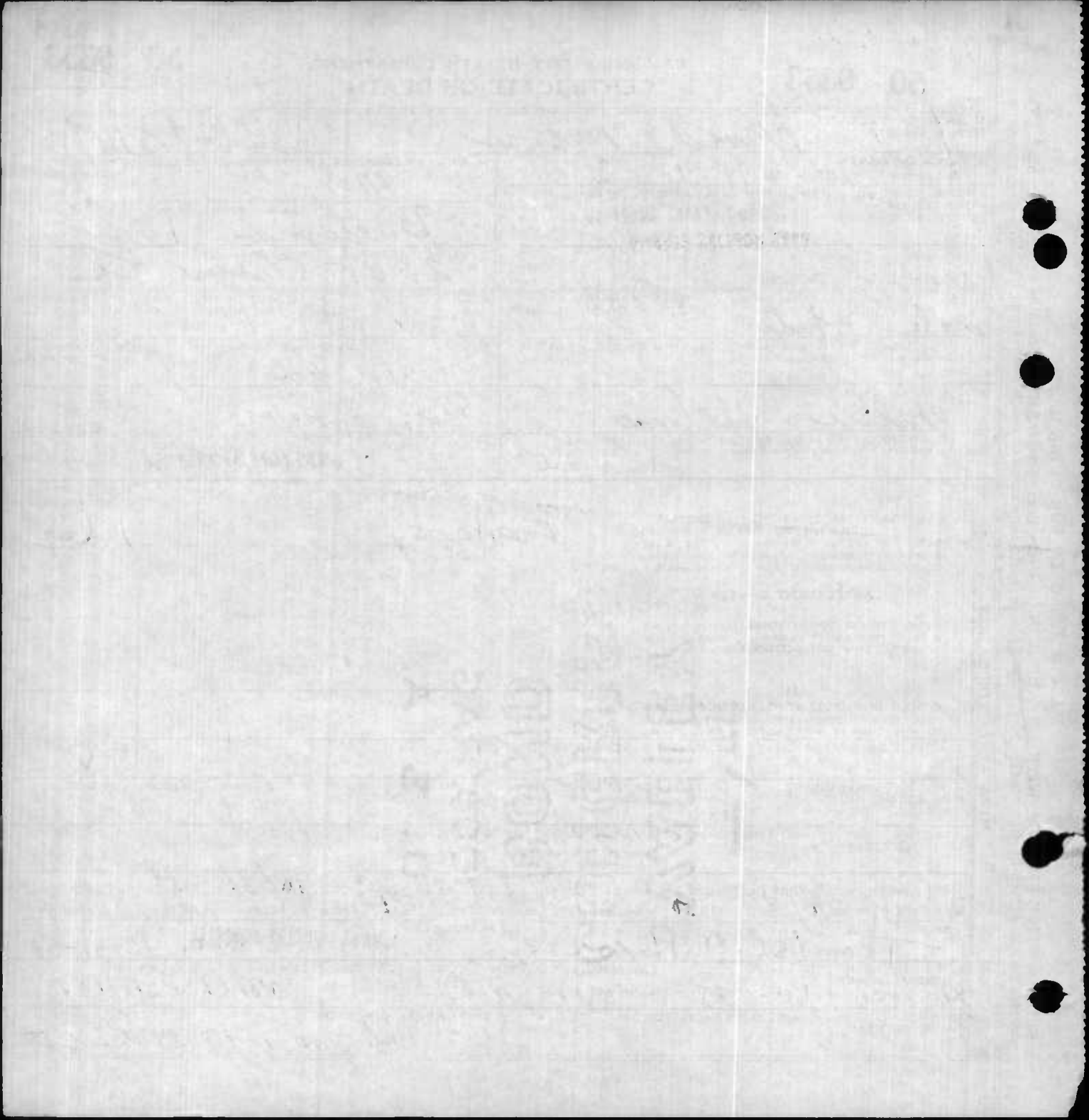
25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc. 1217 St Paul St

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



5-320

50 9354

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9354

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lillie M. Schutz

2. DATE
OF
DEATH

Oct. 31/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

PINE RIDGE

Pine Ridge Nursing Home

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

3138 Cliftmont Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. Md.

D. STREET ADDRESS (If rural, give location)

3138 Cliftmont Ave.

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

April 29, 1877

9. AGE (In years
last birthday)

73 yrs

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Lacher

14. MOTHER'S MAIDEN NAME

Emma---

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Mrs. Thelma Hallameyer, 3314 ADDRESS

18. E902.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Broncho-pneumonia

1 wk.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Fractured left femur

3 wks

DUE TO

CERTIFICATION APPROVED BY

S. H. Dunscomb

M. D.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Heart Block - Hypertension

TIME ON ADT. MEDICAL EXAMINER.

15 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

accident

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

Baltimore (near 3rd St)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

10-9-50

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Lost
balance & fell to floor from commode22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on _____, 19____, and that death occurred at _____ a.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Dunscomb

M. D.

23B. ADDRESS

3105 Belair Rd

23C. DATE SIGNED

11-1-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 3/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

2024 Orleans St.

NOV 15 1950

N 821.0

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WALTON
COOPER
RE

RECEIVED

CLERK

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

L-321

50

9355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

9355

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sophia Litchfield

2. DATE
OF
DEATH

Oct. 30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3010 W. Lanvale St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
3010 W. Lanvale St.5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. Md.

D. STREET ADDRESS (If rural, give location)

3010 W. Lanvale St.

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Feb. 14, 1871

9. AGE (In years,
last birthday)

79

10. Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

----Wickman

14. MOTHER'S MAIDEN NAME

Mary----

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

(If yes, give war or dates of service)

none

16. SOCIAL
SECURITY NO.

none

17. INFORMANT ADDRESS
Mrs. Richard Gress, 3010 W. Lanvale St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1948, 1948 to Oct 30, 1950, that I last saw the deceased alive on Oct 30, 1950 and that death occurred at 11:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

3321 Frederick Ave

Nov 1, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 2/50

24C. NAME OF CEMETERY OR CREMATORY

Balto. Md.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY REGISTRAR'S SIGNATURE
LOCAL REGISTRAR

25. FUNERAL DIRECTOR

ADDRESS

2024 Orleans St.

NOV 5 1950

093d

50 2010

WALTER
BOND
BOOKS
1000
1000
1000

Walter Bond
1000

Walter Bond

P-412
50 9356

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 50 9356
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edwin J Phillips

2. DATE OF DEATH
October 30 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE Md. B. COUNTY Baltimore before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
PINECREST SANATARIUM

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore Brighton 630

D. STREET ADDRESS (If rural, give location)
6705 Mt Vernon Ave.

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

9. AGE (In years last birthday)
92

10. Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter Retired

10B. KIND OF BUSINESS OR INDUSTRY
?

11. BIRTHPLACE (State or foreign country)
Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Albert J. Phillips 6705 Mt Vernon Ave.

18. 420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

CHRONIC MYOCARDITIS
with MYOCARDIAL DEGENERATION

INTERVAL BETWEEN ONSET AND DEATH

4 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

Arteriosclerotic Heart disease

DUE TO

Generalized Arteriosclerosis

Emphysema

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 11, 1950, to October 30, 1950, that I last saw the deceased alive on Oct 28, 1950, and that death occurred at 9:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Malvin N. Borden

M. D.

23B. ADDRESS

2030 W. Fayette St

23C. DATE SIGNED

10/30/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

St Marys

24D. LOCATION (City, town, or county)

Hampden

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Paul E. Schenck, Jr. 3615-17 Belmont Ave.

ADDRESS

NOV 4 1950

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly applied. The correct age is especially important. Physicians: please write the causes of death.

31-32 00

31-32 00

REPORT DATE OF TEST

VALLEY

BRITISH

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9357
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH DAY

2. DATE
OF
DEATH

10/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1823 E. North Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1823 E. North Avenue

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

5/10/1867

9. AGE (In years last birthday)

83

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Casper Kroenert

14. MOTHER'S MAIDEN NAME

Regina

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 10 1950 to Oct 29 1950, that I last saw the deceased alive on 10/26 1950, and that death occurred at 12:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John A. Schenck

M. D.

23B. ADDRESS

1337 S. Charles St.

23C. DATE SIGNED

10/31/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

B

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

John E. Kelly

ADDRESS

- 130 E. Fort Ave.

NOV 1 1950

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1008

1008

1008

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9358

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DAVID S. LANGSTON

2. DATE
OF
DEATH

November 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
before admission)

Maryland

B. COUNTY

City

B. FULL NAME OF (If not in hospital or institution, give street address or
location)HOSPITAL OR
INSTITUTION

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1409 McCulloh Street

c. Length of stay in Baltimore

14 Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

B. DATE OF BIRTH

7/7/1912

9. AGE (In years
last birthday)

38

If Under 1 Year

Months

If Under 24 Hours

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

a helper

10B. KIND OF BUSINESS OR
INDUSTRY

Junk Truck

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Langston

14. MOTHER'S MAIDEN NAME

Martha Sneed

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs Williams - 1813 - Mosher St.

ADDRESS

18. E816.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Skull fracture

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Crushed chest

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

highway

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Crane Highway near Fourth Ave. Glen

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

November 1, 1950 4:15 a.m.

21E. INJURY OCCURRED
WHILE AT ☒ AT WORK ☐

21F. HOW DID INJURY OCCUR?

Truck collided with parked truck

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. H. H.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Nov. 1, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Shipped

24B. DATE

11-3-50

24C. NAME OF CEMETERY OR CREMATORY

Klenson, N.C.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 2 - 1950

REGISTRAR'S SIGNATURE

William H. H. H.

25. FUNERAL DIRECTOR

W. Halstead

ADDRESS

918 - V

VS 151

N 804.2

690 68

Klendon Hill ave. 170c

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B 400
 50 9359

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 9359

BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Dennis Bailey		2. DATE OF DEATH 10/29/1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 3316 Fairfield Road		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City	
c. Length of stay in Baltimore 12 Yrs.		D. STREET ADDRESS (If rural, give location) 3316 Fairfield Road	
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 11/17/1875
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman		10B. KIND OF BUSINESS OR INDUSTRY Water Fisheries	9. AGE (in years, last birthday) 74
11. BIRTHPLACE (State or foreign country) Northumberland Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ellen Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Harry Tolliver		ADDRESS 3316 Fairfield Rd.	
18. 592X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ch. Nephritis & Ure mia		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/2 , 19 50 , to 10/29 , 19 50 , that I last saw the deceased alive on 10/28 , 19 50 , and that death occurred at 7 AM. , from the causes and on the date stated above.			
23A. SIGNATURE B. W. R. H. H.		23B. ADDRESS 2139	23C. DATE SIGNED 10/31/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/2/1950	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State) Northumberland Co. Va.
DATE RECEIVED BY LOCAL REGISTRAR NOV 2 - 1950	REGISTRAR'S SIGNATURE W. H. Williams	25. FUNERAL DIRECTOR Eloy O. Wilson	
		ADDRESS 1000 Bunting Ave.	

100-100000

100-100000

UNITED STATES DEPARTMENT OF JUSTICE

33
+
17

67

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 9360

BIRTH NO. 50600 9360

1. NAME OF DECEASED (Type or Print) THOMAS V. BERRY			2. DATE OF DEATH Oct. 31, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 653 George St.			E. Length of stay in Baltimore 20 Yrs.		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH II/19/1880	9. AGE (In years last birthday) 69	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY All Kind		
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Saran Martin 7II Bradley St			ADDRESS		

18. 442X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular (A) DUE TO Renal Disease		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE Stanley K. Durlacher M.D. 23B. CHIEF MEDICAL EXAMINER.....☐ 23C. DATE SIGNED **Oct. 31, 1950**
MEDICAL INVESTIGATOR.....☒

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **II/3/1950** 24C. NAME OF CEMETERY OR CREMATORY **Mt Calvary Cem.** 24D. LOCATION (City, town, or county) (State) **Brooklyn Md**

DATE RECEIVED BY LOCAL REGISTRAR **NOV 2 - 1950** REGISTRAR'S SIGNATURE Stanley K. Durlacher 25. FUNERAL DIRECTOR Elroy S. Wilson ADDRESS 1000 Brantly Ave

V S 151

97099

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK
CERTIFICATE OF DEATH

NO. 1000

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE		OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT		CORONER		BURIAL		FUNERAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CORONER		SIGNATURE OF BURIAL		SIGNATURE OF FUNERAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE	

5-363
50 9361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9361
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Albert Stewart

2. DATE
OF
DEATH

10/30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Beth City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Anne Arundel

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

5

C. Length of stay in Baltimore

5 1/2

D. STREET ADDRESS (If rural, give location)

Box 517, Glen Burnie

5. SEX

M

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

February 11, 1883

9. AGE (In years last birthday)

67

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired LABORER

10B. KIND OF BUSINESS OR INDUSTRY

Koester's Bakery

11. BIRTHPLACE (State or foreign country)

Anne Arundel Co

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

162 Tobias Stewart

14. MOTHER'S MAIDEN NAME

Miss Louisa Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Susie Stewart, Glen Burnie Md

18. 002 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

9-8-50

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

10-30-50

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/23/1950, to 10/30/1950; that I last saw the deceased alive on 10/30/1950, and that death occurred at 8:45 m., from the causes and on the date stated above.

23A. SIGNATURE

Aristomenes Nicolas

M. D.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

10/30/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-3-50

24C. NAME OF CEMETERY OR CREMATORY

St Marks Cem.

24D. LOCATION (City, town, or county)

A. D. Co. Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, Jr.

25. FUNERAL DIRECTOR

Elroy O Wilson 1000 Brantly Ave

ADDRESS

NOV 2 - 1950

VS 150

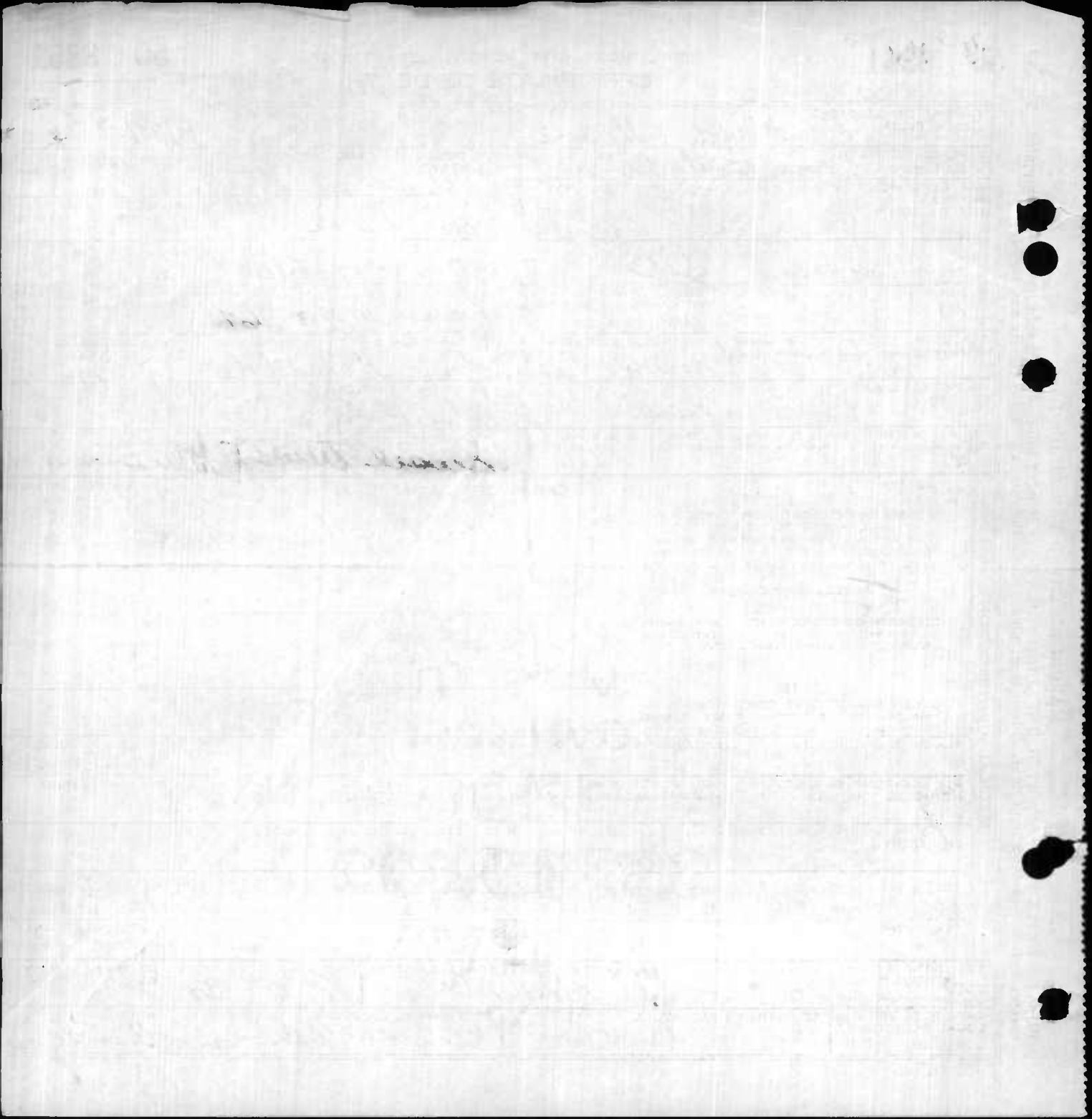
970 44

013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9362

Registered No.

1. NAME OF DECEASED (Type or Print) Albert Crow (Crow) (Crowell)			2. DATE OF DEATH 10-31-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 28 Yrs. Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 110 Bethel Ct. 6-5		
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 9-II-1895	9. AGE (In years last birthday) 55	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Records: B. C. H. 4940 Eastern Avenue		

18. 42010 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Uremia		4 days	
DUE TO					
ANTECEDENT CAUSES		(B) Arteriosclerosis Heart Disease		1 Year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
		(C) Pneumonia		1 Week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-29 , 19 50 , to 10-31 , 19 50 , that I last saw the deceased alive on 10-31 , 19 50 , and that death occurred at 1:35A m., from the causes and on the date stated above.					
23A. SIGNATURE <i>R. S. Rosen</i> M. D.		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 10-31-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE II/2/1950	24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.	24D. LOCATION (City, town, or county) (State) Brooklyn Md.
DATE RECEIVED BY LOCAL REGISTRAR NOV 2 - 1950		REGISTRAR'S SIGNATURE <i>W. H. Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>Elroy O. Wilson 1000 Beauty</i>

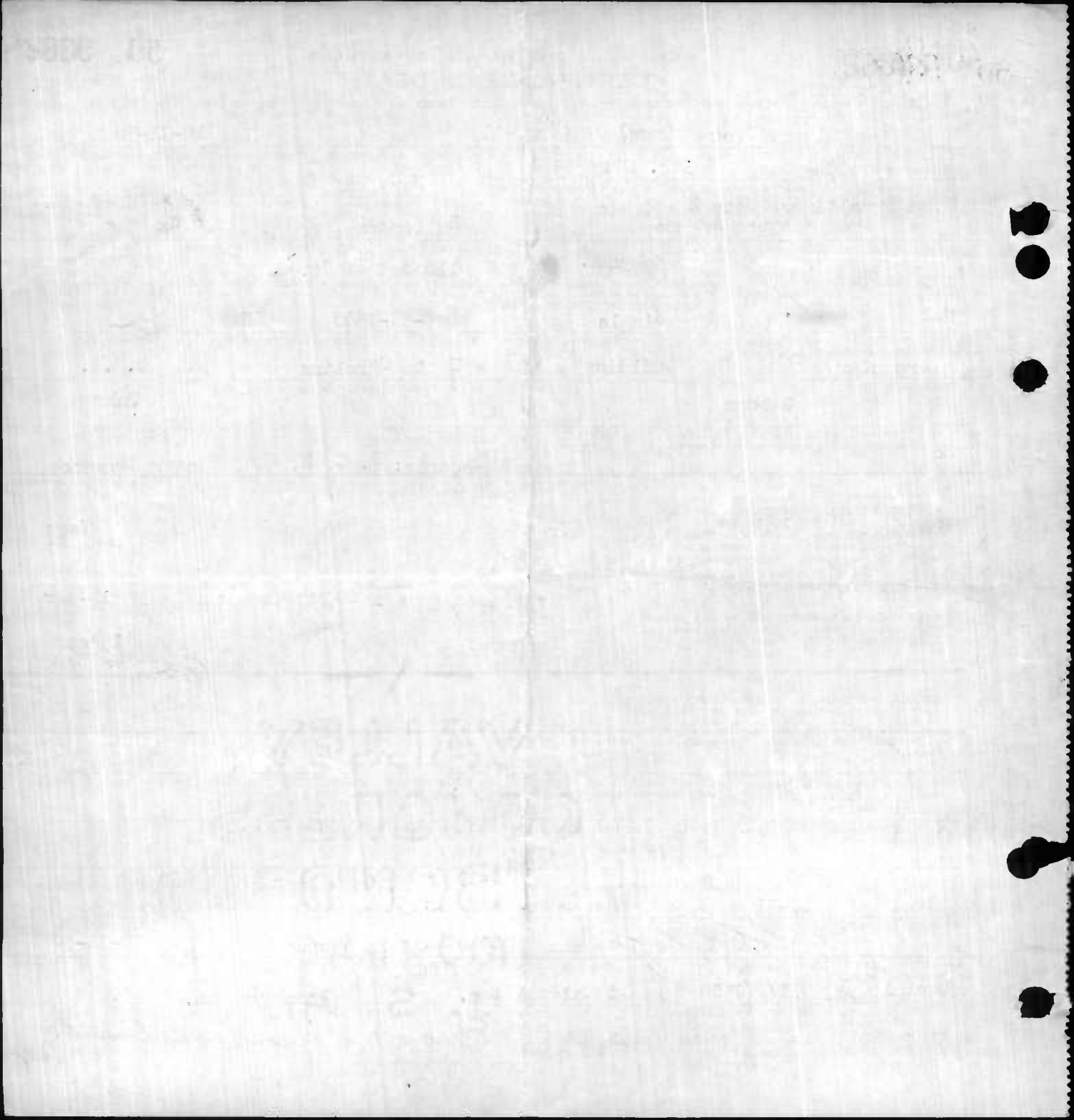
VS 150

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093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN FULLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9363

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Delores Jane Hamlin

2. DATE OF DEATH

Oct. 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

11-24-34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

6. CITY OR TOWN (If outside corporate limits, write it (city), and give township)

Baltimore 15-01

7. STREET ADDRESS (If rural, give location)

1365 N. Stricker St

8. Length of stay in Baltimore

540

9. SEX

Female

Colored

School

School

Robert Hamlin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown)

20

10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Saeveria Armstrong

15. INFORMANT

JOHNS HOPKINS HOSPITAL

16. SOCIAL SECURITY NO.

17. ADDRESS

18. 193X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain tumor

DUE TO

19. ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/27, 1950, to 10/31, 1950, that I last saw the deceased alive on 10/31, 1950, and that death occurred at 9 A.M. from the causes and on the date stated above.

23A. SIGNATURE

Lee M. Bass

M. O.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10/31/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-4-1950

24C. NAME OF CEMETERY OR CREMATORY

2nd Calvary Cem. Brooklyn Md

24D. LOCATION (City, town, or county)

Brooklyn Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 2-1950

REGISTRAR'S SIGNATURE

Frederick Williams, Jr.

25. FUNERAL DIRECTOR

Elroy B. Wilson 1000 Brantly Ave

ADDRESS

"

Ependymoma of 4th ventricle"

See Document File 50-9363

11-20-50

Es

02, 12, 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9364

BIRTH NO. 50 9364

1. NAME OF DECEASED (Type or Print) JOSEPH P. KLINGAMAN			2. DATE OF DEATH 1 Nov 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Mercy Hosp.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Belair		
C. Length of stay in Baltimore 4 yrs			D. STREET ADDRESS (If rural, give location) 25 E. Courtland St.		
5. SEX m	6. COLOR OR RACE wh	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Nov 19, 1887	9. AGE (In years last birthday) 62 63	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist			10B. KIND OF BUSINESS OR INDUSTRY Drug		
11. BIRTHPLACE (State or foreign country) Penna			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James K. Klingaman			14. MOTHER'S MAIDEN NAME Laura Ely		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service) unk			16. SOCIAL SECURITY NO.		
17. INFORMANT Mercy Hosp. Records			ADDRESS		

18. **181X** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of the urethra
DUE TO

INTERVAL BETWEEN ONSET AND DEATH
9 mos +

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 10-21-50		19B. MAJOR FINDINGS OF OPERATION Extension of malignancy to ant. abd. wall		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

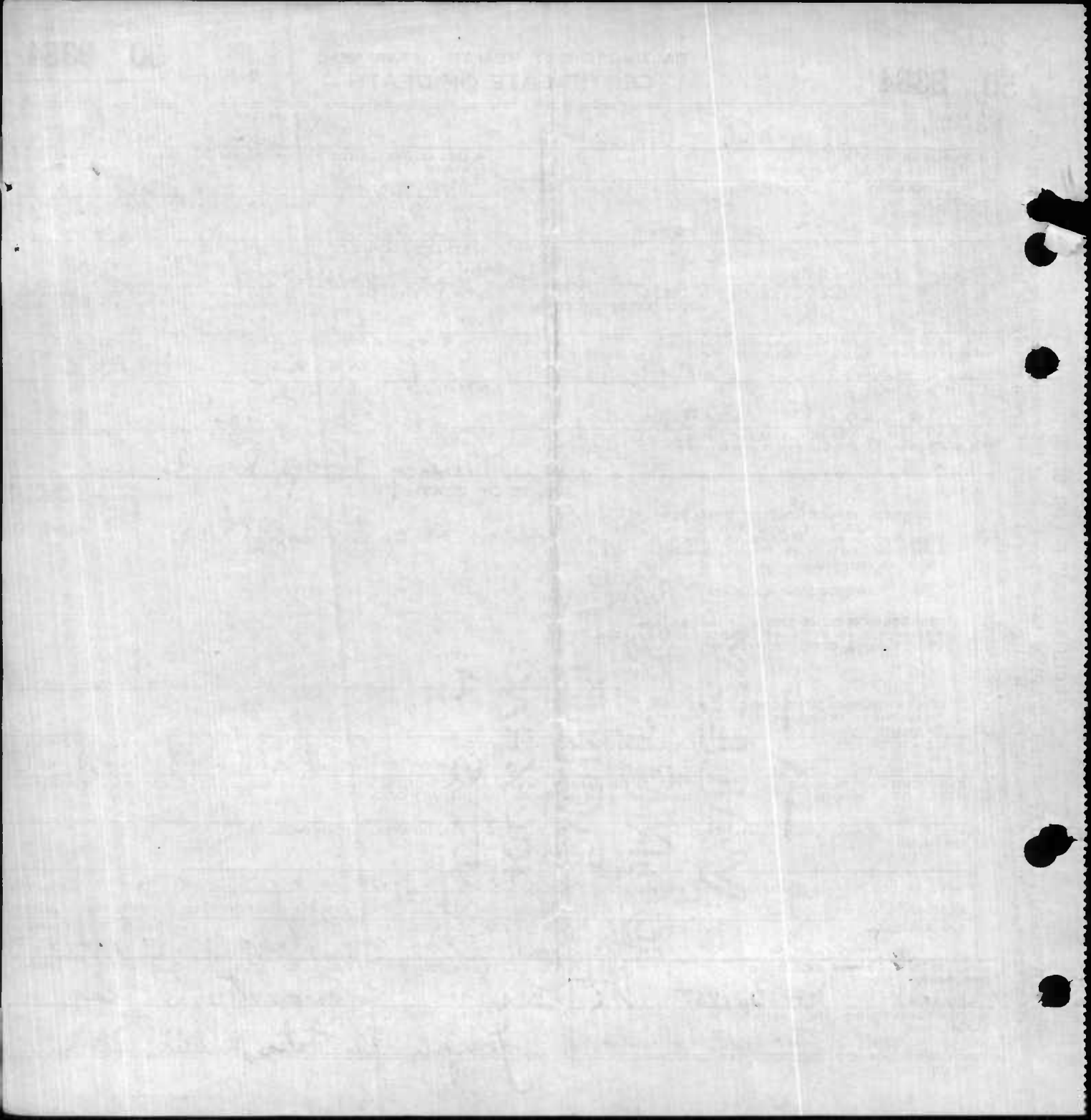
22. I hereby certify that I attended the deceased from **11 Oct**, 1950, to **1 Nov**, 1950, that I last saw the deceased alive on **1 Nov**, 1950, and that death occurred at **4:50 pm.**, from the causes and on the date stated above.

23A. SIGNATURE Fowler F. Whittemore	23B. ADDRESS Mercy Hosp.	23C. DATE SIGNED 1 Nov 1950
---	------------------------------------	---------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov 3, 1950	24C. NAME OF CEMETERY OR CREMATORY St. Jacobs	24D. LOCATION (City, town, or county) (State) Laurens, Penna
DATE RECEIVED BY LOCAL REGISTRAR NOV 2 - 1950	REGISTRAR'S SIGNATURE Thurston Williams	25. FUNERAL DIRECTOR Joseph F. Foster, Bel Air, Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9365

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROSIE EUPHROSINA SRB

2. DATE
OF
DEATH

October 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 6028 Old Harford Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Beech Hill Conv. Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

48 years

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

614 N. Luzerne Avenue

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Dec. 11, 1877

9. AGE (In years
last birthday)

72

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

James Vacek

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lillian DePetrus, dht, above

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Cardio-Vascular
disease. & Cerebral Hemorrhage.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 10/24, 1950, to 10/29, 1950, that I last saw the
deceased alive on 10/29, 1950, and that death occurred at 2:30 m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph R. Liberto

M. D.

23B. ADDRESS

3508 Bank St.

23C. DATE SIGNED

11/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Hill Cemetery

24D. LOCATION (City, town, or county)

Horner's Lane, Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 2 - 1950

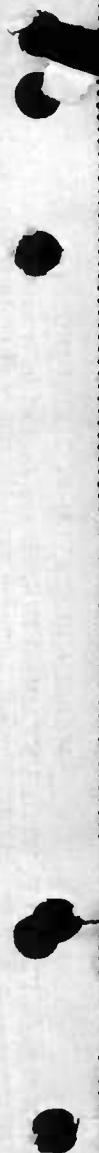
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
2601-3-5 E. Madison St.

ADDRESS



G-432

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9366

BIRTH NO. 50 9366

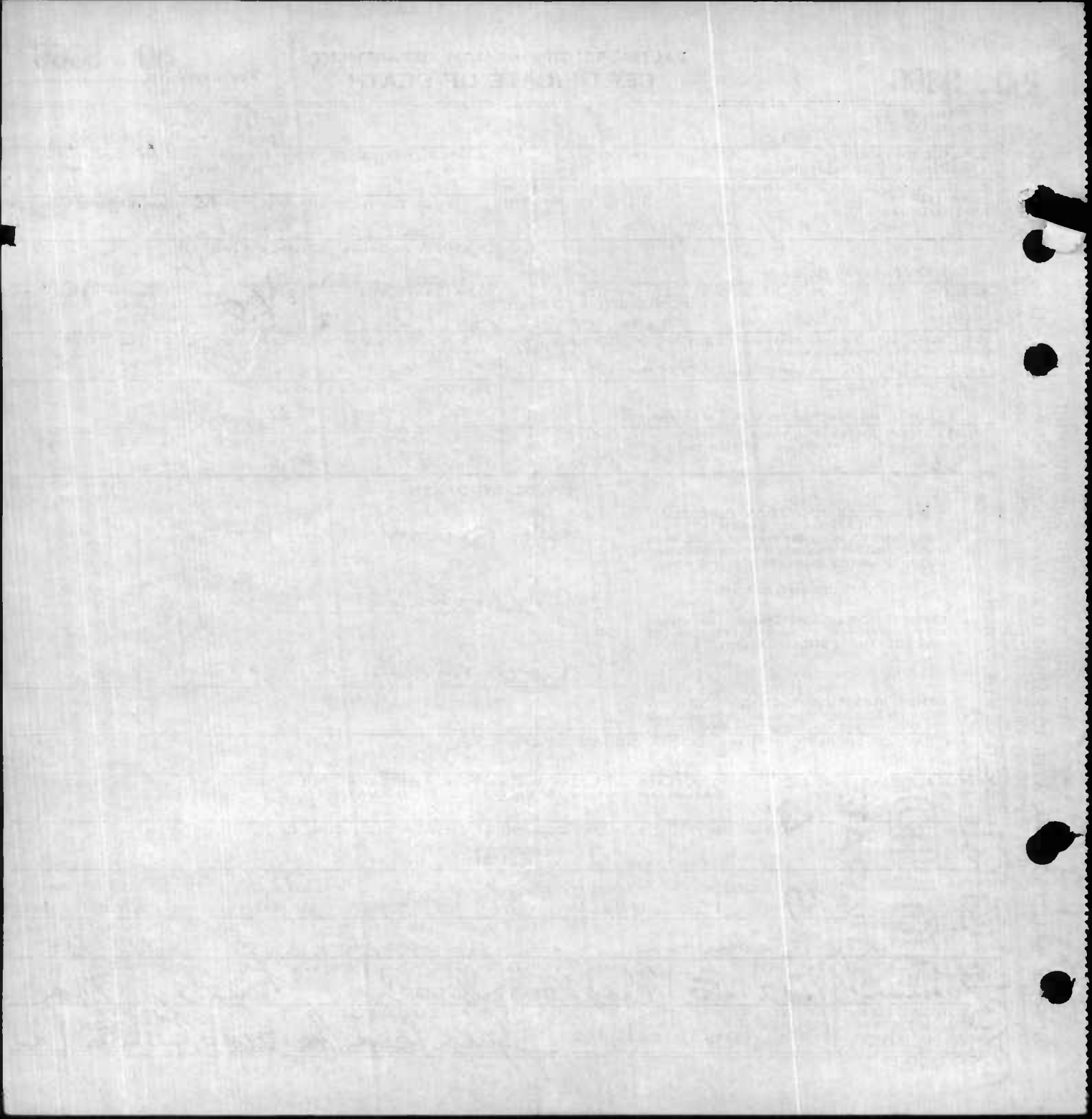
1. NAME OF DECEASED (Type or Print) <i>Louis Goldstein</i>			2. DATE OF DEATH <i>Nov. 1, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>15-11</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i>		
c. Length of stay in Baltimore <i>30</i> Yrs. <i>1</i> Mo. <i>1</i> Day			D. STREET ADDRESS (If rural, give location) <i>3211 Sequoia Ave</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>Wht</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 21, 1882</i>		9. AGE (In years last birthday) <i>68</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Body Builder</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Automobile (M)</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Emmanuel Goldstein</i>			14. MOTHER'S MAIDEN NAME <i>Racheal Steiner</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT ADDRESS <i>Morris Goldstein, same</i>		

18. <i>177X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i> DUE TO <i>Uremia</i> <i>Carcinoma of Prostate</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10/27</i> , 1950, to <i>11/1</i> , 1950, that I last saw the deceased alive on <i>11/1</i> , 1950, and that death occurred at <i>8:15</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Paul F. Richardson</i>		23B. ADDRESS <i>Mercy Hosp.</i>		23C. DATE SIGNED <i>11/1/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-2-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mishkows Israel</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto, Md</i>		25. FUNERAL DIRECTOR <i>Jack Lewis</i>		26. ADDRESS <i>2100 Eatan Pl</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 2-1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>		27. ADDRESS <i>550 30</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE CORRECTED 11-10-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9367

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NATHAN I. ROSENBERG

2. DATE
OF
DEATH

11-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

00 2607 Reisterstown Rd

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
2607 Reisterstown Road

c. Length of stay in Baltimore

64

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug. 15, 1876

9. AGE (In years last birthday)

74

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Tailor - SELF

11. BIRTH PLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Shanice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Auntie Rosenberg - Same

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Insufficiency

DUE TO

(B) Spasmodic 3 lung

DUE TO

(C) Edema

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1949, to Nov 1, 1950, that I last saw the deceased alive on 11/1/50, 19, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

W. J. B. B. B.

23B. ADDRESS

2040 Gutter

23C. DATE SIGNED

11/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-2-50

24C. NAME OF CEMETERY OR CREMATORY

Shaarei Tfiloh

24D. LOCATION (City, town, or county)

Balto Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. J. B. B. B.

25. FUNERAL DIRECTOR

Jack Lewis

ADDRESS

2100 Gutter Pl

VS 150

5906E

094a

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

Received of Mr. J. I. Goosbeck

the sum of \$100.00 for the purchase of

the sum of \$100.00 for the purchase of

the sum of \$100.00 for the purchase of

the sum of \$100.00 for the purchase of

the sum of \$100.00 for the purchase of

the sum of \$100.00 for the purchase of

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the sum of \$100.00 for the purchase of

the sum of \$100.00 for the purchase of

the sum of \$100.00 for the purchase of

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9368

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANCES L. POWDER

2. DATE
OF
DEATH

OCT 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

3627 MALDEN AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3627 MALDEN AVE

C. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

5. SEX

FEMALE

WHITE

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JAN 6 1913

9. AGE (In years,
last birthday)

37

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

HERBERT BOWERS

14. MOTHER'S MAIDEN NAME

ANNIE M. REYNOLDS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ANNIE M. REYNOLDS-3627 MALDEN AVE

18.

171X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Carcinoma Cervix Uteri

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ HOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 15, 1950, to Oct 31, 1950, that I last saw the deceased alive on Oct 31, 1950, and that death occurred at 6:30 m., from the causes and on the date stated above.

23A. SIGNATURE

J. Shorofsky M.D.

M. O.

23B. ADDRESS

601 N. Howard St

23C. DATE SIGNED

11/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Nov 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county) (State)

Pittie Highway Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

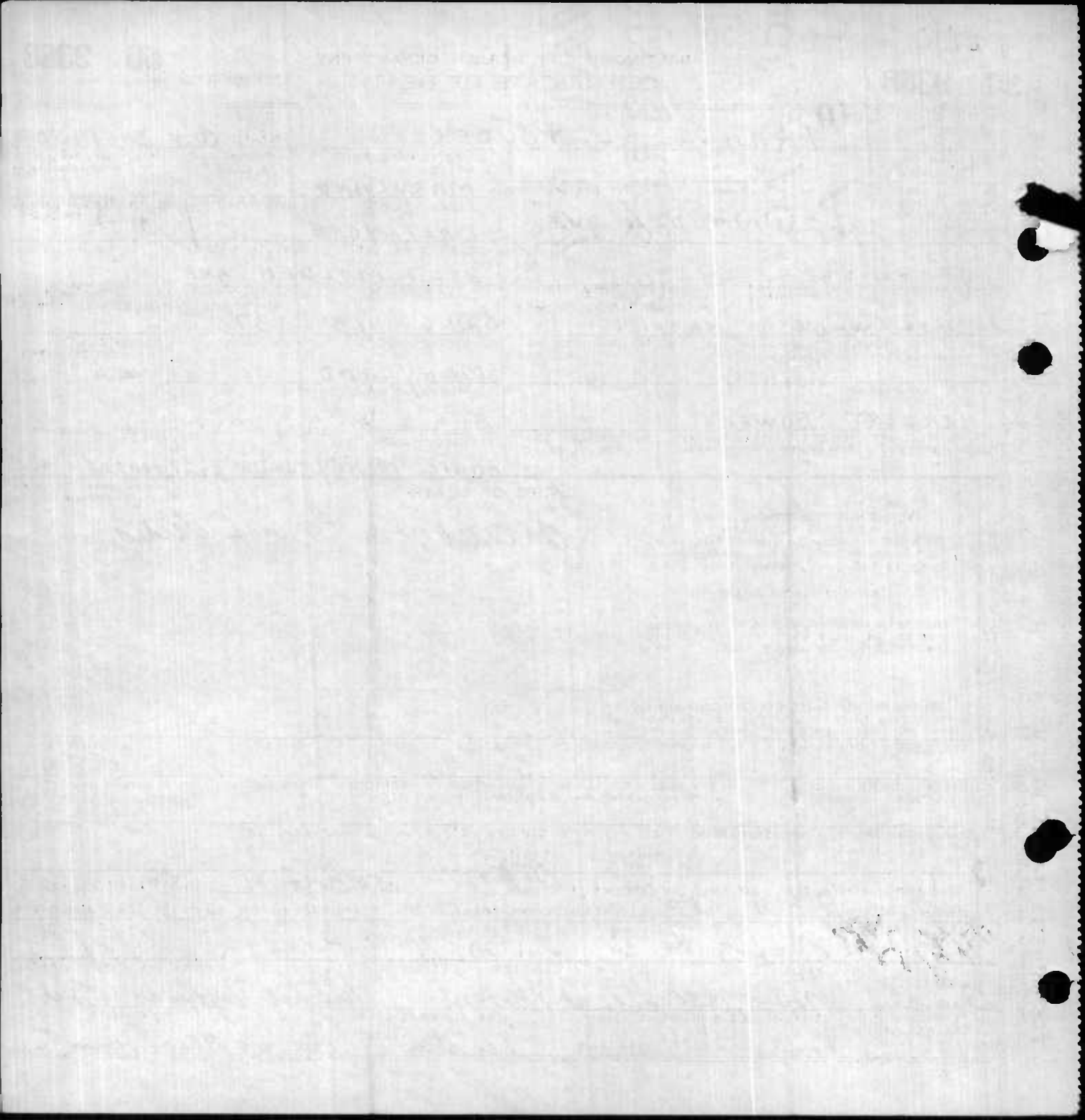
Austin E. Donovan-3818 Roland Ave

VS 150

048a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly correct age is especially important. Physicians: please write the causes of death clearly and legibly.



W-460

50 9369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9369

Registered No. _____

BIRTH NO.			1. NAME OF DECEASED (Type or Print) Charles E. Wheeler			2. DATE OF DEATH Nov. 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____					
B. FULL NAME OF HOSPITAL OR INSTITUTION 4943 Denmore Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			D. STREET ADDRESS (If rural, give location) 4943 Denmore Avenue		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			5. SEX male			6. COLOR OR RACE white		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed			8. DATE OF BIRTH Aug. 6, 1861			9. AGE (In years last birthday) 89		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Receiver at Terminal Balto. Transit			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Charles E. Wheeler			14. MOTHER'S MAIDEN NAME Sarah E. Rathol		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			16. SOCIAL SECURITY NO. none			17. INFORMANT ADDRESS Mrs. Sarah E. Rolfes, 4943 Denmore Avenue		

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterograde cardiac - vascular disease.			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH 5 mos.		
DUE TO (A) _____			DUE TO (B) _____			DUE TO (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from June 19th to Oct 30th , 19 50 , that I last saw the deceased alive on Oct 30th , 19 50 , and that death occurred at 8:45 Am. , from the causes and on the date stated above.								
23A. SIGNATURE L. Emmett Green			23B. ADDRESS M.D. Rte Bldg - Balto.			23C. DATE SIGNED Nov. 1, 1950.		
24A. BURIAL, CREMATION, REMOVAL (Specify) burial			24B. DATE 11/4/50			24C. NAME OF CEMETERY OR CREMATORY Lorraine		
24D. LOCATION (City, town, or county) (State) Woodlawn Maryland			25. FUNERAL DIRECTOR Wm. Cook, Inc.			ADDRESS 1217 St. Paul Street		

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1988 00

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9370

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

William J. Murdock

2. DATE
OF
DEATH

November 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

605 S. Robinson Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
605 S. Robinson Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

B. DATE OF BIRTH

Nov. 26, 1865

9. AGE (In years last birthday)

84

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Ship Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Spedden Ship Bldg Co.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James E. Murdock

14. MOTHER'S MAIDEN NAME

Winifred Hughes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Leona B. Murdock, 605 S. Robinson St.

1B.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) *Arteriosclerotic C.V. Disease*

DUE TO (CEREBRO)

(B) *Cerebro Vascular Thrombosis*

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

2 yrs.

Oct 28/50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Oct 28, 1950* to *Nov 1, 1950*, that I last saw the deceased alive on *Oct 31, 1950*, and that death occurred at *4:24 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE

J. Schinck

23B. ADDRESS

842 S. East Ave

23C. DATE SIGNED

11-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify)
burial

24B. DATE

11/1/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

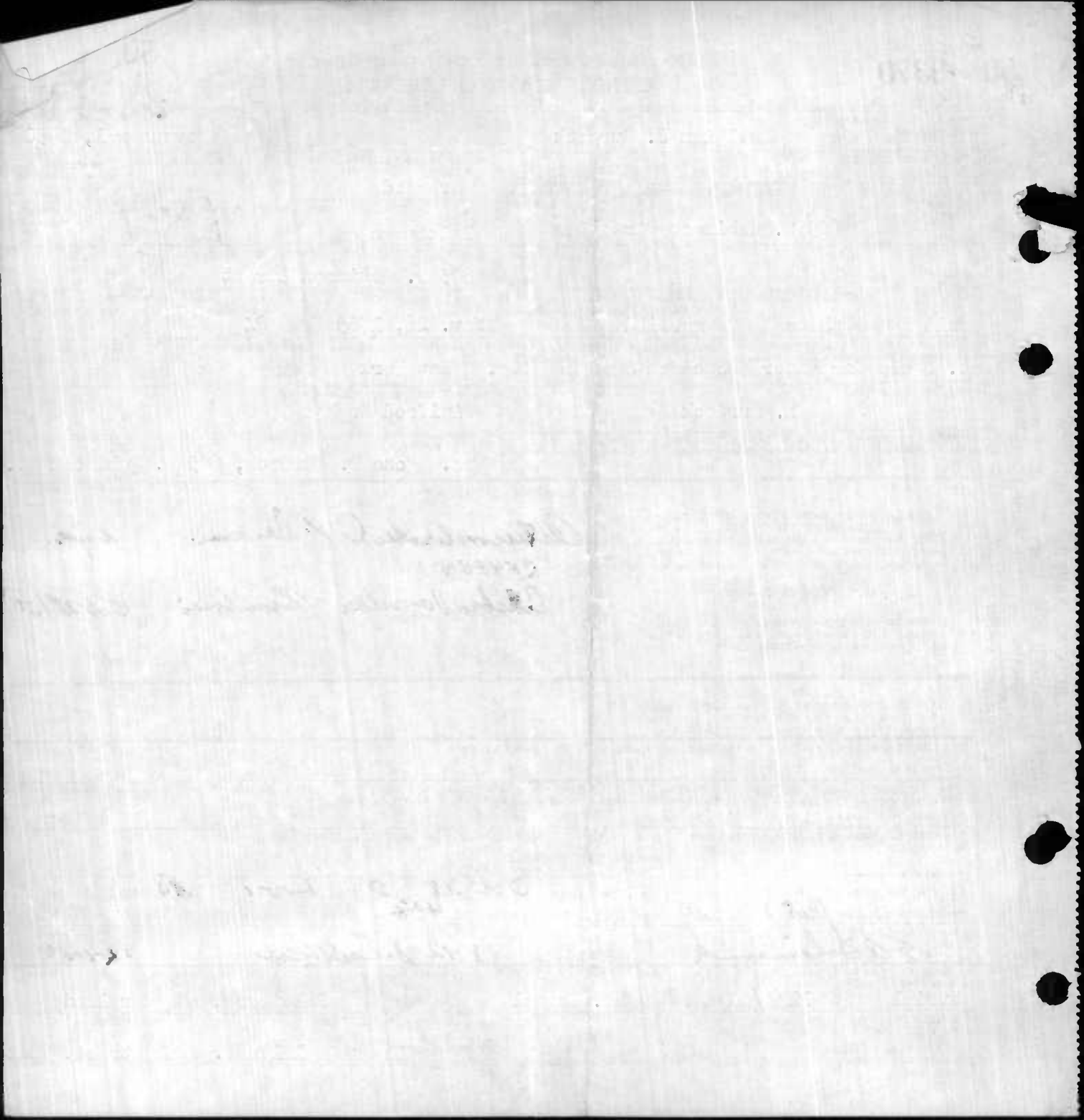
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc. 1217 St. Paul Street, Balt



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9371
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES BONAR

2. DATE

OF

DEATH October 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

1 Baltimore

D. STREET ADDRESS (If rural, give location)

620 S. Fulton Avenue

C. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

11/9/1930

9. AGE (In years last birthday)

20

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Loader

10B. KIND OF BUSINESS OR INDUSTRY

Firestone Rubber Co

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Chas. F. Bonar

14. MOTHER'S MAIDEN NAME

Leazel Richards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. E902.3

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Skull fracture

DUE TO

ANTECEDENT CAUSES

(B) Intracranial hemorrhage

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

warehouse

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Firestone Rubber Co. 526 S. Light St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

October 31, 1950 3.00pm.

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Fell down elevator shaft

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. Smith

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D.

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Nov. 1, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

11/2/50

24C. NAME OF CEMETERY OR CREMATORY

Rockland

24D. LOCATION (City, town, or county)

Ohio

ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR

NOV 2-1950

REGISTRAR'S SIGNATURE

William H. Smith

25. FUNERAL DIRECTOR

4th Park Inc. 1217 St. Paul St

VS 151

N 803.2

970 40

186 a

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

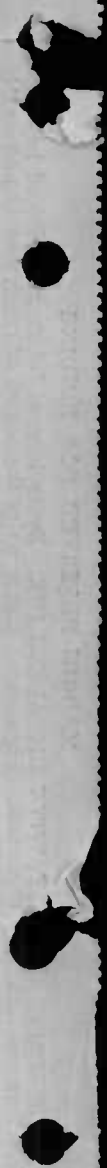
1938

50

STATE OF NEW YORK
OFFICE OF THE COMMISSIONER OF DEWITT

1938

50



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 9372

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM (SANS) (SIMS) SAMS			2. DATE OF DEATH October 30, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26-56		
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1213 Jopplin Street (Joplin ST. 24)		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 3, 1901		9. AGE (In years last birthday) 49 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10B. KIND OF BUSINESS OR INDUSTRY Casual	11. BIRTH PLACE (State or foreign country) Dobreville N.C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME (Unknown) Sams			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 217-4-0433	17. INFORMANT ADDRESS Blanche Sams 1213 Joplin St		

18. **420.1** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Stanley H. Duncanson</i> M.D.		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED 10-31-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/3/50	24C. NAME OF CEMETERY OR CREMATORY Saint Peters	24D. LOCATION (City, town, or county) (State) Balto. Md.		

DATE RECEIVED BY LOCAL REGISTRAR NOV 2 1950	REGISTRAR'S SIGNATURE <i>Wm. Cook Inc.</i>	25. FUNERAL DIRECTOR Wm. Cook Inc.	ADDRESS 1217 St. Paul St.
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V S 151

97099

094a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

MARGIN RESERVED FOR BINDING

570

10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

570

DATE OF BIRTH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9373

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Jenette Smith

2. DATE
OF
DEATH

10/31/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

White

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

403 North Durham Street

D. STREET ADDRESS (If rural, give location)

403 North Durham Street

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday) Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Walter White 403 North Durham Street

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐NOT WHILE ☐22. I hereby certify that I attended the deceased from 9/23, 1950, to 10/31, 1950, that I last saw the
deceased alive on 10/31, 1950, and that death occurred at 6:25 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

11/3/1950

Mt Calvary Cem.

Brooklyn Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

NOV 2 - 1950

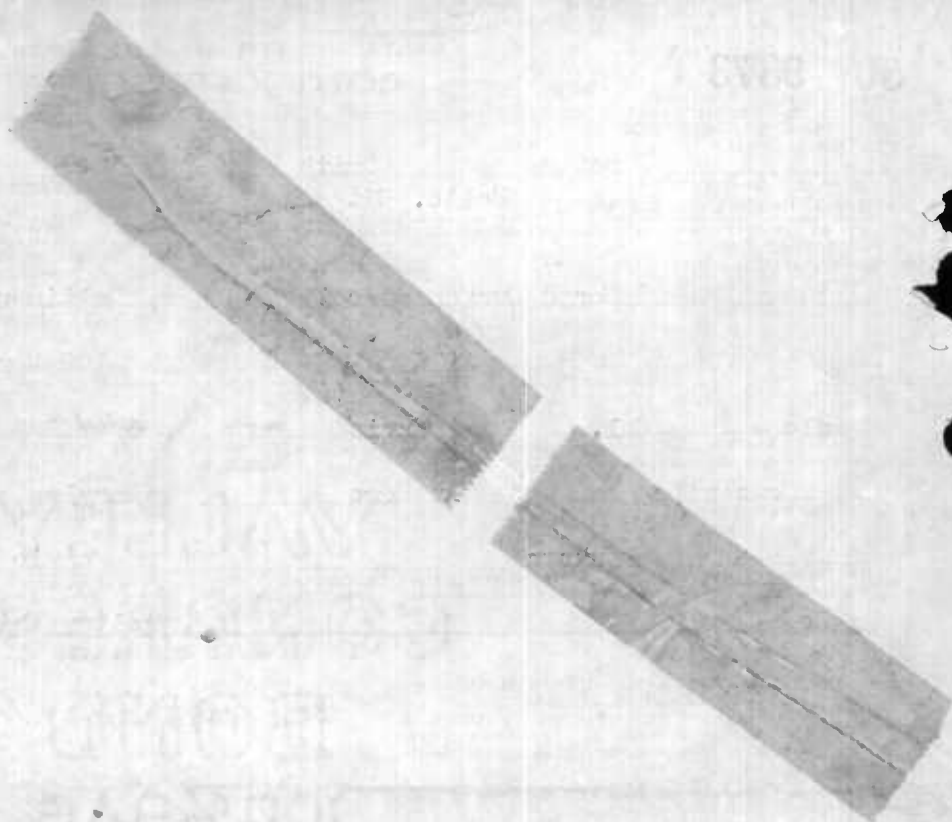
VS 150

Elyo O. Wilson 1000 Brantly Ave

.046.8

8378 08

8378 08



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

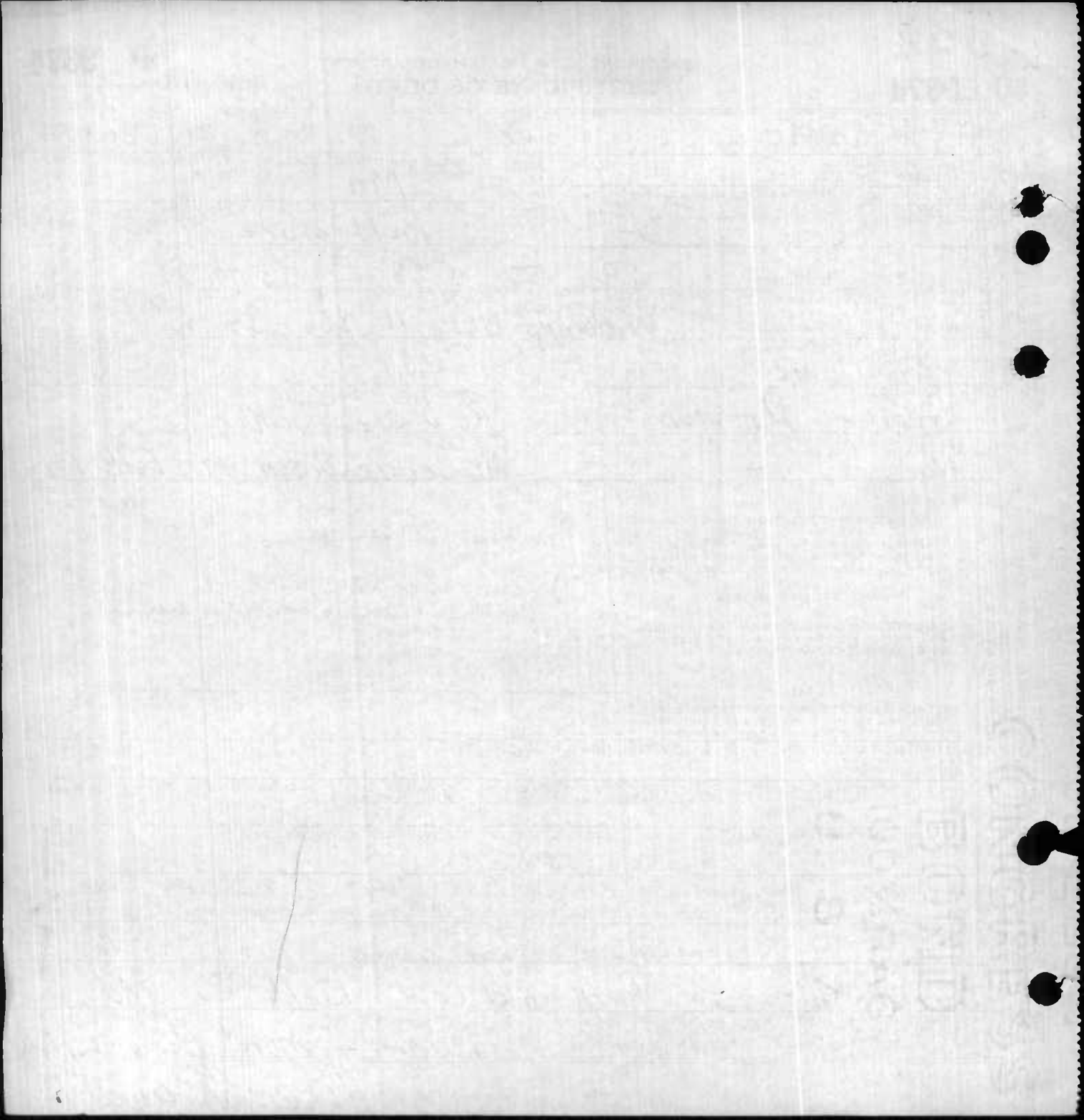
50 9374
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) SARABELLE LOWE		2. DATE OF DEATH 31 Oct 50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Hosp 27 N Carey St		C. CITY OR TOWN (If outside corporate limits, write FULL and give township) Baltimore 9-03	
c. Length of stay in Baltimore 50 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 528 E 35th St	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 11-1866 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birth day) 84
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME George Preston		14. MOTHER'S MAIDEN NAME Rebecca Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs Berthe Wilson		ADDRESS 4333 Falls Rd	

<p>18. 443X</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) Cerebral Thrombosis</p> <p>DUE TO</p> <p>(B) Arteriosclerotic and Hypertensive Cardiovascular disease</p> <p>DUE TO</p> <p>(C) _____</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3 Oct 1950 , to 31 Oct 1950 , that I last saw the deceased alive on 30 Oct 1950 , and that death occurred at 10⁴⁵ Am. , from the causes and on the date stated above.					
23A. SIGNATURE Emil H. Henning Jr.		23B. ADDRESS 601 Wians Way		23C. DATE SIGNED 31 Oct 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-3-50		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Md 937		25. FUNERAL DIRECTOR Burgee Funeral Home 3631 Park Rd			
DATE RECEIVED BY LOCAL REGISTRAR NOV 2 - 1950		REGISTRAR'S SIGNATURE Washington Williams, Md		ADDRESS Grace Burgee Jr.	



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9375
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

W

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.2. DATE
OF
DEATH4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY (before admission))

Md.

C. CITY OR TOWN

Hampstead

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

June 9-1894

9. AGE (In years
last b. day)

56

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Laura

17. INFORMANT

Allen M. Palmer

ADDRESS

2611 Hampden Ave.

18. 202X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

Multiple Myeloma A

ACUTE Paroxysmal Atrial Tachycardia
Multiple Pulmonary Infarcts

Rt Hemiplegia - old

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

WORK ☐

NOT WHILE

AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15-50, 19, to 10-31, 1950, that I last saw the
deceased alive on 10-31, 1950, and that death occurred at 12:45 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Waren Glase

23B. ADDRESS -

University Hosp

23C. DATE SIGNED

10-31-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 3-1950

24C. NAME OF CEMETERY OR CREMATORY

Grave Run

24D. LOCATION (City, town, or county)

Carroll Co. Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 2-1950

REGISTRAR'S SIGNATURE

L. Williams

25. FUNERAL DIRECTOR

K. Rourke Funeral Home 3631 Falls Road

ADDRESS

Horace R. Rourke

VS 150

644 4E

0552

1711

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9376**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES G. BLAKENEY

2. DATE
OF
DEATH

10/30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **568 Md.** B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Luthan Hospital of Md.

C. CITY OR TOWN (If outside corporate limits, write full name and give township)
Baltimore 27-17

C. Length of stay in Baltimore

71 yrs

D. STREET ADDRESS (If rural, give location)

5686 Merville Ave 5606 Merville

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

wid

8. DATE OF BIRTH

July 26-1879

9. AGE (In years last birthday)

71

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Retired 2 years

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles H. Blakney

14. MOTHER'S MAIDEN NAME

Lina E. Karr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

212-12-5119A

17. INFORMANT

Mrs. Elizabeth B. Studd 4024 Roland Ave.

18.

420.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **Acute Posterior Myocardial Infarction**

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Coronary Thrombosis**

DUE TO

(C) **Coronary Atherosclerosis**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Oct. 30, 1950** to **Oct. 30, 1950** that I last saw the deceased alive on **Oct. 30, 1950**, and that death occurred at **11 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE

M. H. Edwards

23B. ADDRESS

Luthan Hosp. Md.

23C. DATE SIGNED

10/31/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 2-1950

24C. NAME OF CEMETERY OR CREMATORY

Green Mount

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 2-1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Burgee Funeral Home 3631 Falls Road

ADDRESS

Horace F. Burgee

094a

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9377
Registered No.

BIRTH NO. 536 50 9377		1. NAME OF DECEASED (Type or Print) <i>Andrew F Andruszak</i>		2. DATE OF DEATH <i>October 31 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Md.</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1-01</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>3018 Dillon St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
c. Length of stay in Baltimore <i>60 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>3018 Dillon St.</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct 25 1950</i>	9. AGE (In years last birthday) <i>70</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Acetylene Burner</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Arundel Ship Corp</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Andruszak</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <i>214-01-2145</i>		17. INFORMANT <i>Mrs. Catherine Andruszak</i>	
18. <i>161X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Lung</i> DUE TO		CAUSE OF DEATH <i>Cardiac Failure</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan</i> , 1950, to <i>Oct</i> , 1950, that I last saw the deceased alive on <i>10/29</i> , 1950, and that death occurred at <i>5:15</i> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>John J. Jaworski</i>		23B. ADDRESS <i>2711 Eastern Ave</i>		23C. DATE SIGNED <i>10/1/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov 4 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St Stanislaus Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Dundalk Are Balts Md.</i>		25. FUNERAL DIRECTOR <i>John J. Duda Inc</i>		25. ADDRESS <i>2829 Hudson St</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 2-1950</i>		REGISTRAR'S SIGNATURE <i>Washington Williams, M.D.</i>			

685 3U

047a

THE

OFFICE OF THE

SECRETARY



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9378**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LAWRENCE

CHOICE

2. DATE
OF
DEATH

October 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland (Detroit, Mich)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1010 S. Eutaw Street

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 15, 1900

9. AGE (In years last birthday)

50

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fish Packer

10B. KIND OF BUSINESS OR INDUSTRY

Shipping Fish (w)

11. BIRTHPLACE (State or foreign country)

Greenville, S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. Choice

14. MOTHER'S MAIDEN NAME

Annie White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary Jackson 628 S. Paca St

18. **420.0**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Arteriosclerotic heart disease**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fatty infiltration of liver

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R S Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

10-30-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/3/50

24C. NAME OF CEMETERY OR CREMATORY

Bakers Chapel

24D. LOCATION (City, town, or county) (State)

Greenville, S.C.

DATE RECEIVED BY LOCAL REGISTRAR

NOV 2-1950

REGISTRAR'S SIGNATURE

Wm. H. Williams, M.D.

25. FUNERAL DIRECTOR

Chas. H. Wilson

ADDRESS

512 Carrollton Ave

V S 151

69063

124 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-250
50 9379BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9379

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lillian Sisson

2. DATE
OF
DEATH

Nov 1st 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1823 N. Port St

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto

8-02

D. STREET ADDRESS (If rural, give location)

1823 N Port St

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

Female White

Widow

Nov 22nd 1874

76

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

Housewife

-

Md

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Benjamin Butler Butler

Reguardy Mc Guire

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Melissa Sisson 2945 St

18. 447.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Myocardial failure

6 Mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

arterial hypertension
generalized arteriosclerosis10 yrs -
25 yrs -

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948 to 1 Nov 1950, that I last saw the
deceased alive on Oct 31, 1950, and that death occurred at 6 A M., from the causes and on the date, stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Lillian Sisson

M. D.

2900 Alameda Rd

11/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Nov 3rd 1950 Fork Christian Cem

Fork Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 2-1950

Lillian Sisson

Leo S. Cook 1701-03 N Patterson Park Ave

VS 150

97

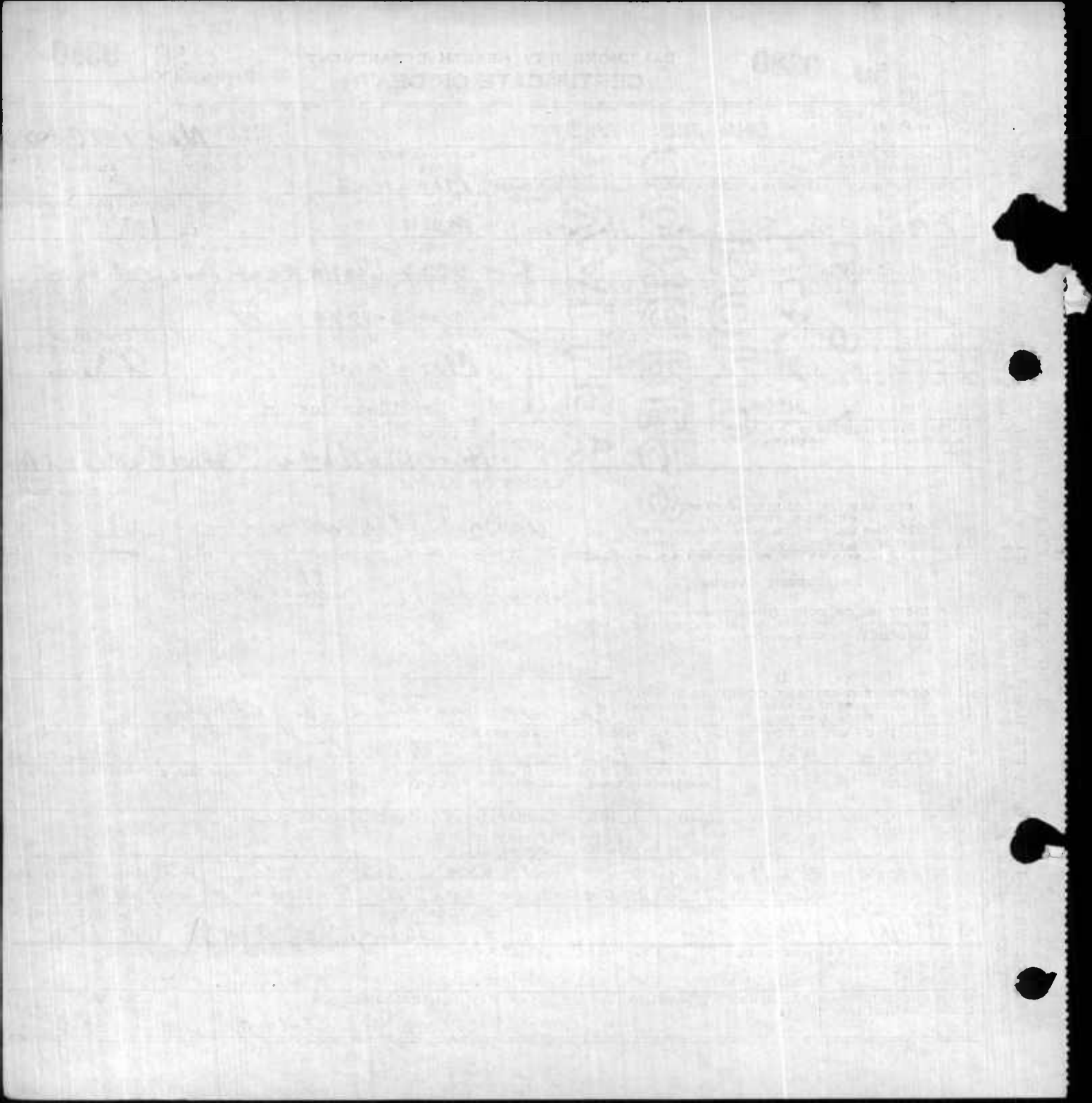
MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9380**

BIRTH NO. 50 9380		1. NAME OF DECEASED (Type or Print) LAMAR JAMES HUTTON WHITAKER		2. DATE OF DEATH Nov. 1 - 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE Hospital			C. CITY OR TOWN (If outside corporate limits write RURAL and give township) Baltimore		
C. Length of stay in Baltimore Yrs. 30 Mos. 0 Days 5			D. STREET ADDRESS (If rural, give location) 3027 OAKCREST AVE. #14		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Sept 3 - 1879	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer		10B. KIND OF BUSINESS OR INDUSTRY City Police Dept.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James L. Whitaker			14. MOTHER'S MAIDEN NAME Marcilean Hutton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Marcilean White 3027 Oakcrest Ave	
18. 332X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis DUE TO Generalized arteriosclerosis DUE TO Benign prostatic hypertrophy			INTERVAL BETWEEN ONSET AND DEATH 3 wks.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10-4-50		19B. MAJOR FINDINGS OF OPERATION Retropharyngeal abscess		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-25 , 19 50 , to 11-1 , 19 50 , that I last saw the deceased alive on 11-1 , 19 50 , and that death occurred at 1454 m., from the causes and on the date stated above.					
23A. SIGNATURE G. W. Borhovic		23B. ADDRESS Franklin Sq. Hosp		23C. DATE SIGNED 11-1-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/50		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25. FUNERAL DIRECTOR Mr. J. Dickner & Sons		ADDRESS Balto. Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 2 1950		REGISTRAR'S SIGNATURE W. H. Williams		137a	

773 93



Z-500
50 9381BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9381
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELSIE ROSELLA ZINN

2. DATE
OF
DEATH

Oct. 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

3013 Gwynns Falls Pkwy.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3013 Gwynns Falls Pkwy.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Oct. 14, 1878

9. AGE (In years
last birthday)

72

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wm. H. Bleakley

14. MOTHER'S MAIDEN NAME

Laura Jane Graverein

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Horace T. Jacobs

ADDRESS

3013 Gwynns Falls Pkwy

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Cardio Vascular Disease
Hypertension

10 yrs

10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Vascular Failure
Cerebral Hemorrhage

9 da

2 da

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 26, 1950, to Oct 30, 1950, that I last saw the
deceased alive on Oct 30, 1950, and that death occurred at 7:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

J. E. Williams

M. D.

23B. ADDRESS

1202 St Paul St

23C. DATE SIGNED

11/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/3/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Thos. J. Dickner & Sons - Balt

Md.

NOV 2 1950

J. E. Williams, M.D.

937

1303

1303

50 9382

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WALTER M. WEILEPP

2. DATE OF DEATH
Nov, 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
306 Thornhill Rd.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreD. STREET ADDRESS (If rural, give location)
306 Thornhill Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

Oct. 14, 1889

9. AGE (In years last birthday)

61

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Investment Broker10B. KIND OF BUSINESS OR INDUSTRY
Securities

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Adolph Weilepp

14. MOTHER'S MAIDEN NAME

Estelle Lohmeyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. Ruth E. Weilepp 306 Thornhill Rd.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

3 min.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Thrombo-phlebitis

3 years

(C) DUE TO

arterio sclerosis

?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Angio neurotic edema

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1954 to Nov 1, 1950, that I last saw the deceased alive on Oct 21, 1950, and that death occurred at 8:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

Nov. 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 2 - 1950

Huntington Williams, M.D.

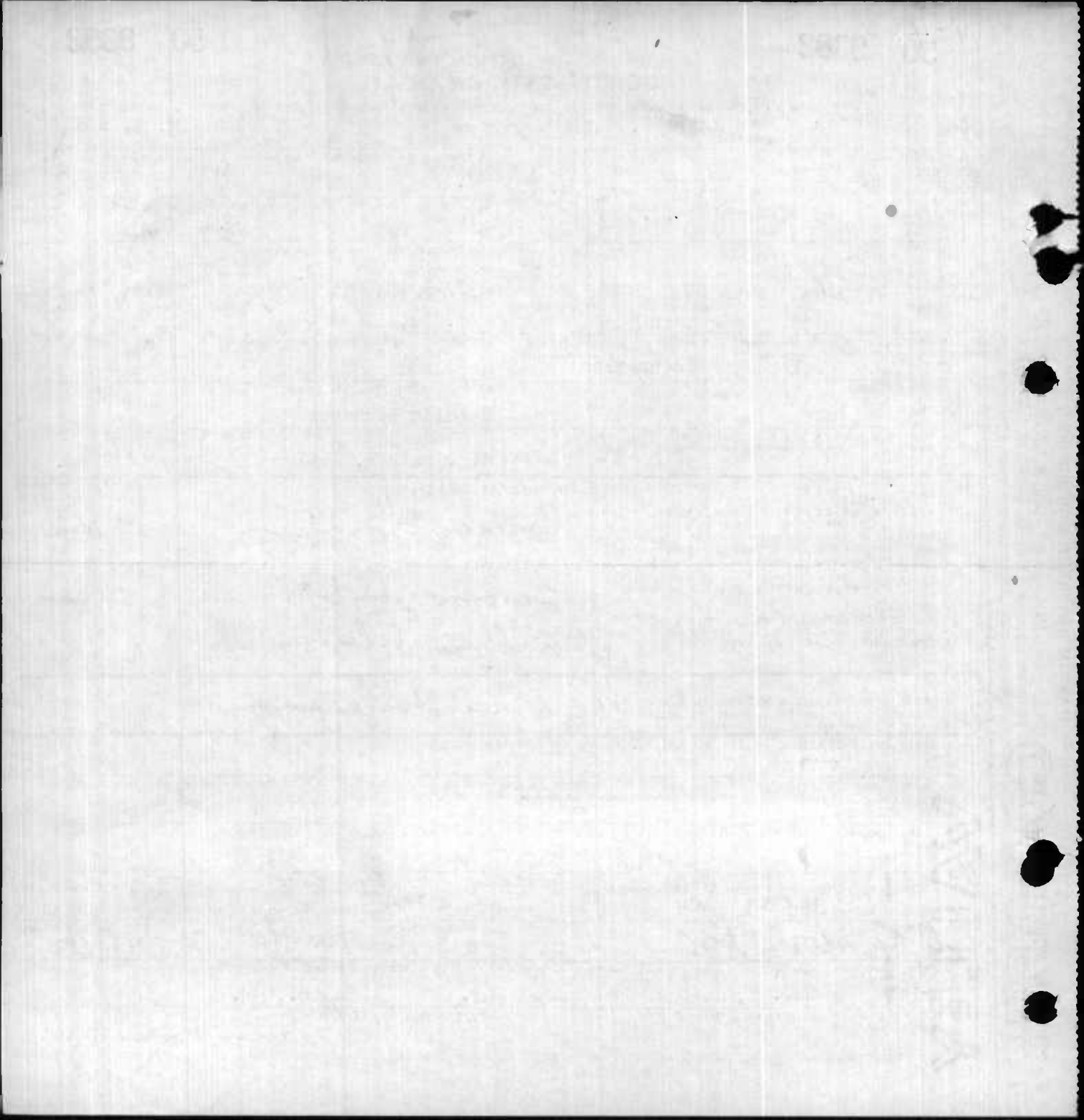
29072

94a Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



50 9383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9383

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Patrick Hughes

2. DATE
OF
DEATH

11/1/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

204 S. Stricker St.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

204 S. Stricker St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

D. STREET ADDRESS (If rural, give location)

204 S. Stricker St.

c. Length of stay in Baltimore

65 yrs

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widower

8. DATE OF BIRTH

June 4, 1862

9. AGE (in years
last birthday)

88

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

retired

10b. KIND OF BUSINESS OR
INDUSTRY

Brook

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

David Hughes

14. MOTHER'S MAIDEN NAME

Margaret Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Mary A. Hughes 204 S. Stricker St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Occlusion

Several Hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Generalized Arterio-sclerosis

Many years

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21e. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 31, 1950, to Oct 31, 1950, that I last saw the
deceased alive on Oct 31, 1950, and that death occurred at 8 A. m., from the causes and on the date stated above.

23a. SIGNATURE

Abram Goldman

M. D.

23b. ADDRESS

206 S. Gilman St.

23c. DATE SIGNED

11/1/50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

11/4/50

24c. NAME OF CEMETERY OR CREMATORY

New Cathedral

24d. LOCATION (City, town, or county)

4300 Old Red Road

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John J. Brown 901 Bellvue St.

NOV 2 - 1950

VS 150

0940

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

4. The fourth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

5. The fifth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

50 9384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9384

1. NAME OF DECEASED (Type or Print) <i>Mrs. Lillian Marguerite Cornell</i>		2. DATE OF DEATH <i>November 2 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Hospital for the Women of Maryland</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore <i>?</i>		D. STREET ADDRESS (If rural, give location) <i>3911 Stokes Drive (29)</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>June 9, 1915</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (in years last birthday) <i>35 years</i>
13. FATHER'S NAME <i>John Hill</i>		11. BIRTHPLACE (State or foreign country) <i>Gillespie Illinois</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>?</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
16. SOCIAL SECURITY NO. <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Lillian Ramsey</i>	
17. INFORMANT <i>Patient</i>		ADDRESS	
18. <i>199 d</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>(A) METASTATIC CARCINOMA OF PERITONEUM AND OVARY</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 WEEKS</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>(B) CARCINOMA OF INTERESTING PERITONEUM & UNKNOWN</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>September 6, 1950</i>		19B. MAJOR FINDINGS OF OPERATION <i>Metastatic Carcinoma of Peritoneum and Ovary. Probably Intestinal in Origin</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>September 25, 1950</i> , to <i>November 2, 1950</i> , that I last saw the deceased alive on <i>1-NOV</i> , 1950, and that death occurred at <i>1 A.M.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>E. Carubalady</i>		23B. ADDRESS <i>BALTO MD 521 MEDICAL ARTS BLDG</i>	
23C. DATE SIGNED <i>11-2-50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>11-2-50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Ocean View</i>		24D. LOCATION (City, town, or county) (State) <i>same</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 2-1950</i>		REGISTRAR'S SIGNATURE <i>Wm Cook Inc</i>	
25. FUNERAL DIRECTOR <i>Wm Cook Inc</i>		ADDRESS <i>1217 St Paul city (2)</i>	

The office of the
Commissioner of the
General Land Office
Washington, D.C.
has received from
the Surveyor General
of the Territory of
Idaho a report
of the Surveyor
General of the
Territory of Idaho
relative to the
land owned by
the United States
in the Territory
of Idaho.

For information
of the Department
the following
report is submitted
for the year
ending March 31st
1880.

The Surveyor
General of the
Territory of Idaho
has reported that
the land owned by
the United States
in the Territory
of Idaho is
as follows:

1. The land owned
by the United States
in the Territory
of Idaho is
as follows:

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9385
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY D. WILSON

2. DATE
OF
DEATH

November 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

817 N. Calhoun Street

c. Length of stay in Baltimore

60

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

9. AGE (In years
last birthday)

94

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Brady

14. MOTHER'S MAIDEN NAME

Lethia Bramley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Emma Leach 6 Union St N.M.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Second and third degree burns of
thorax, head, and neck (Postmortem)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
m. WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William Brooks

23B. CHIEF MEDICAL EXAMINER.....
M.D. ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....23C. DATE SIGNED
Nov. 1, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 4/50

24C. NAME OF CEMETERY OR CREMATORY

Crown Mt. M. Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

V. Brooks

14637 N. Carey St

From Med. Exam. office by phone 11/2/50 - Estimer

"Had hot plate on, when heart attack
overcame her, fell over on hot plate,
clothes caught fire (after death) "

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9386
Registered No. 50 9386

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) Minnie C. Seaton

2. DATE OF DEATH Oct. 31, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY _____

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
318 S. Lehigh St.

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

7. STREET ADDRESS (If rural, give location)
318 S. Lehigh St.

8. LENGTH OF STAY IN BALTIMORE
Yrs. _____ Mos. _____ Days _____

9. SEX F 10. COLOR OR RACE W 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W

12. DATE OF BIRTH Oct. 14, 1866 13. AGE (In years; last birthday) 84 14. If Under 1 Year Months: Days 15. If Under 24 Hours Hours Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
at home

17. KIND OF BUSINESS OR INDUSTRY _____

18. BIRTHPLACE (State or foreign country)
Baltimore

19. CITIZEN OF WHAT COUNTRY? _____

20. FATHER'S NAME
Andrew Dosch

21. MOTHER'S MAIDEN NAME
Mary Sauter

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____

23. SOCIAL SECURITY NO. _____

24. INFORMANT
George Seaton 634 S. Lehigh St.

25. ADDRESS _____

18. 420.1 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 6/2, 1940 to 10/31, 1950, that I last saw the deceased alive on 10/28, 1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE Charles H. Brown 23B. ADDRESS 3123 East Ave 23C. DATE SIGNED 10/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 11/3/50 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn 24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR NOV 2 - 1950 REGISTRAR'S SIGNATURE Thurston Williams, M.D. 25. FUNERAL DIRECTOR Delancey P. Hoffman ADDRESS 1639 Broadway

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

094a

1000

STATE OF NEW YORK

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9387
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Karl L. Koellner

2. DATE
OF
DEATH

Oct. 31/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

1222 S. Carey St.

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1222 S. Carey St.

C. Length of stay in Baltimore

Life

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 20, 1903

9. AGE (in years last birthday)

47

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sheet Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY

Dixie Manufacturer

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Louis Koellner

14. MOTHER'S MAIDEN NAME

Martha Frank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Frieda Dailey, 1222 S. Carey St.

18. **443X**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Congestive heart failure 3 days

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

cardiovascular disease
(Hypertensive)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10/29** 19**50**, to **10/31**, 19**50**, that I last saw the deceased alive on **10/30**, 19**50**, and that death occurred at **12:45** P.m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Dailey

23B. ADDRESS

1226 Tanager St.

23C. DATE SIGNED

11/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 3/50

24C. NAME OF CEMETERY OR CREMATORY

Western, Edmondson Ave. & Longwood St. Balto. Md.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 2 - 1950

REGISTRAR'S SIGNATURE

Anthony J. Williams, M.D.

25. FUNERAL DIRECTOR

Harry H. Rustyke

ADDRESS

4101 Edmondson Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death early and legibly.

50 383M

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE

50 383M

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9388

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mrs. Leatha Bell

2. DATE
OF
DEATH

November 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

Hospital for the Women of Maryland

C. CITY OF TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

205 West Lorraine Avenue (17)

C. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

12/18/1895

9. AGE (In years
last birthday)

54 years

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

United States

13. FATHER'S NAME

Rev. J. Burrows

14. MOTHER'S MAIDEN NAME

Jane Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Myocardial Infarction due to atherosclerosis coronary thrombosis

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Cholelithiasis

DUE TO

(C) Anemia, secondary, cause undetermined

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

OF INJURY

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 10/25 1950, to 11/1 1950, that I last saw the
deceased alive on 11/1 1950, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Mark E. Hax, Jr.

M. D.

23B. ADDRESS

Women's Hosp

23C. DATE SIGNED

11/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 2 - 1950

Funtington Williams, M.D.

Ulrich Funeral Home, Blundell

VS 150

94 a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9389
Registered No. 50 9389

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Gosling "Baby Gwynne"

2. DATE
OF
DEATH

NOV 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

H.L. OPO

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital, give street address or HOSPITAL OR INSTITUTION)

JOHN HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

ANN ARBOR

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months; DaysIf Under 24 Hours
Hours; Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

M.D.

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Gosling "MD"

14. MOTHER'S MAIDEN NAME

Emil.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHN HOPKINS HOSPITAL ADDRESS

18. 754.4

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)
DUE TOCongenital Heart Disease Life
CyanoticINTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Pneumonia

2 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 8 PM 11-1, 1950 to 11:55 PM 11-1, 1950, that I last saw the
deceased alive on 11-1, 1950 and that death occurred at 11:55 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 2 - 1950

Huntington Williams, M.D.

Ulrich Funeral Home, 200 F. Calver St.

1912

CERTIFICATE OF DEATH

1912

George L. Thomas
#1

12 10 1912

422

8-1

James C. [illegible]

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 9390**

BIRTH NO. **50 9390**

1. NAME OF DECEASED
(Type or Print)

Mary Eliz. Rumpf

2. DATE
OF
DEATH

10-30-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

**Baltimore City Hospitals
4940 Eastern Avenue**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3816 Fait Ave.

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

Oct. 4, 1883

9. AGE (In years last birthday)

67

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

(D)

14. MOTHER'S MAIDEN NAME

(D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18. **331X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebrovascular Accident**

One Week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Hypertension**

15 years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10-23**, 19**50**, to **10-30**, 19**50**, that I last saw the deceased alive on **10-30**, 19**50**, and that death occurred at **8:55P** m., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Crogen M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-31-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 3-50

24C. NAME OF CEMETERY OR CREMATORY

Mountland Memorial

24D. LOCATION (City, town, or county)

Taylor Ave. Balto Co.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John S. Connelley Esq.

NOV 2 - 1950

VS 150

083a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death early and legibly.

1000

1000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9391

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary E. Oerman

2. DATE
OF
DEATH

11/1/50 2:30 a.m.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Windsor Nursing Home

C. CITY OR TOWN

(If outside corporate limits, give RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

16 N. Washington St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

4/24/1886

9. AGE (In years last birthday)

64

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Klingenstein

14. MOTHER'S MAIDEN NAME

Katherine (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Melvin Oerman 1209 Rutland Ave

18. 581.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver

INTERVAL BETWEEN ONSET AND DEATH

6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 3 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. R. Johnson

23B. ADDRESS

403 Med Art Bg

23C. DATE SIGNED

11-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/3/50

24C. NAME OF CEMETERY OR CREMATORY

Balto

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Md.

25. FUNERAL DIRECTOR

ADDRESS

Wm Bok Inc. 1217 St. Paul St.

VS 150

1246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9392**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CAPT. JOHN W. POWELL

2. DATE
OF
DEATH

Nov. 2 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Mercy Hospital
Life

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

125 N. Lakewood Ave

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 3, 1886

9. AGE (In years last birthday)

64

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mariner

10B. KIND OF BUSINESS OR INDUSTRY

Own business

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George W. Powell

14. MOTHER'S MAIDEN NAME

Cecilia Hodges

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

Hospital Record

ADDRESS

18.

4 x 2.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Longestive Heart failure**
DUE TO **Generalized & Valvular Atherosclerosis**
(B) **sclerotic border Vascular disease**

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 Days approx
2 yrs +

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cholelithiasis & appendicitis for chronic cholelithiasis & cholelithiasis

19A. DATE OF OPERATION

10/30/50

19B. MAJOR FINDINGS OF OPERATION

Chronic cholelithiasis & cholelithiasis

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct 28**, 19**50**, to **Nov 2**, 19**50**, that I last saw the deceased alive on **Nov 2**, 19**50**, and that death occurred at **5:00 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE

Leonard G. Humber

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

Nov 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

11/4/50

24C. NAME OF CEMETERY OR CREMATORY

Meadow Ridge

24D. LOCATION (City, town, or county)

Dorsey, Md.

DATE RECEIVED BY LOCAL REGISTRAR

NOV 2 - 1950

REGISTRAR'S SIGNATURE

Huntington Williams

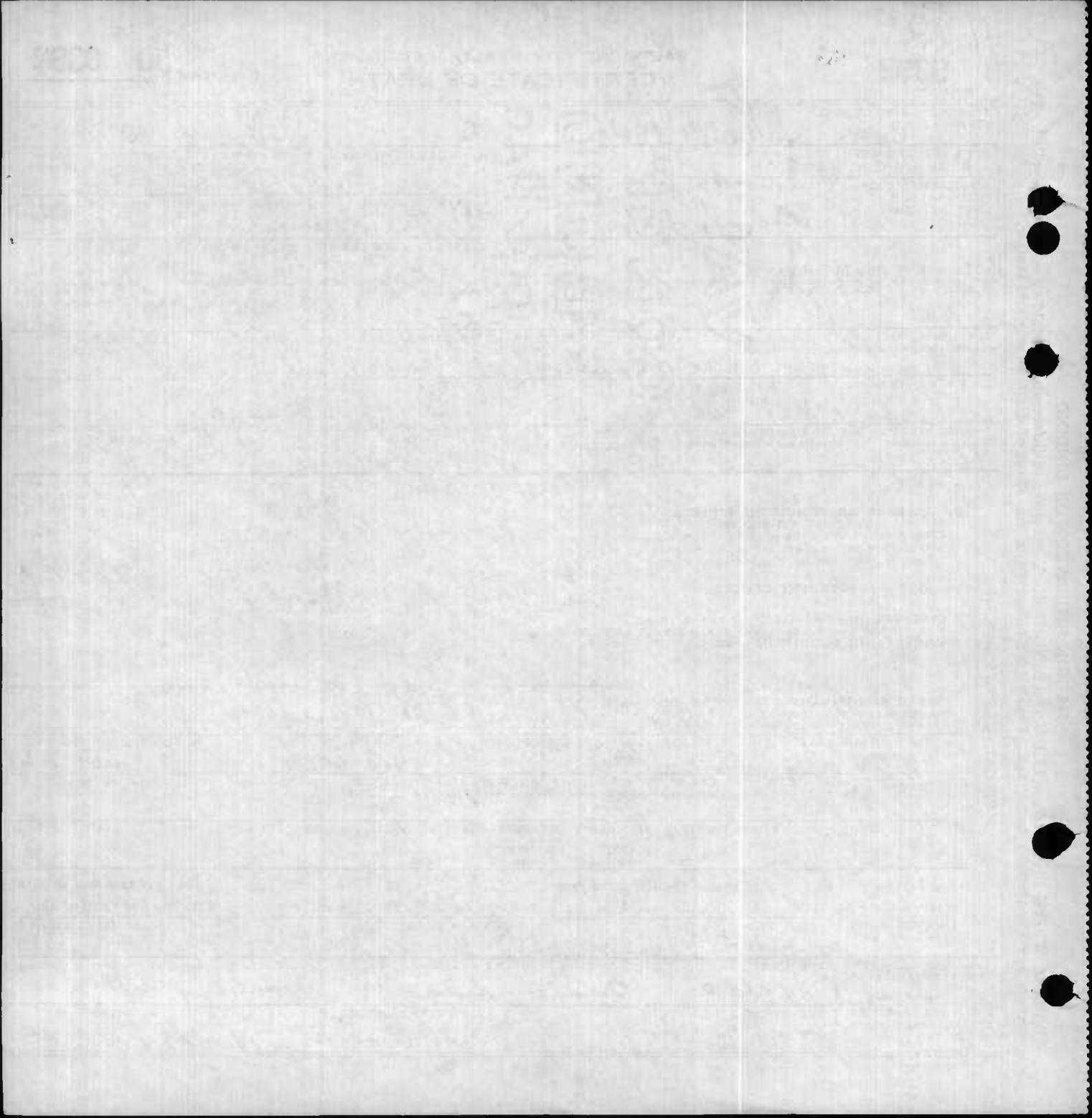
25. FUNERAL DIRECTOR

Wm. Cook, Inc. 1217 E. Paul St

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9393

Registered No.

50 9393
BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET CORNELIUS FASSINGER		2. DATE OF DEATH Nov. 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ohio B. COUNTY Vermillion	
B. FULL NAME OF HOSPITAL OR INSTITUTION Church Home of Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Vermillion	
c. Length of stay in Baltimore 3 1/2 years		D. STREET ADDRESS (If rural, give location) Linwood Park	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec 2, 1874
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 75
13. FATHER'S NAME John Horn		14. MOTHER'S MAIDEN NAME Elizabeth Braun	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Rev. Ralph L. Fassinger - Vermillion, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	

18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 5 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 10/28 , 19 50 , to 11/2 , 19 50 , that I last saw the deceased alive on 11/1 , 19 50 , and that death occurred at 12:15 A. M., from the causes and on the date stated above.				
23A. SIGNATURE 1/ Reed Carroll M. D.		23B. ADDRESS Church Home of Hospital		23C. DATE SIGNED 11/2/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 11/2/50	24C. NAME OF CEMETERY OR CREMATORY Lorain, Ohio		24D. LOCATION (City, town, or county) (State) Lorain, Ohio
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Wm. J. Vickner & Son, Balto Md.		25. FUNERAL DIRECTOR ADDRESS

10-10-03

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

ALBANY, N.Y.

IN SENATE,
January 10, 1903.

REPORT
OF THE
ATTORNEY GENERAL,
JAMES C. CLARK,
FOR THE YEAR
1902.

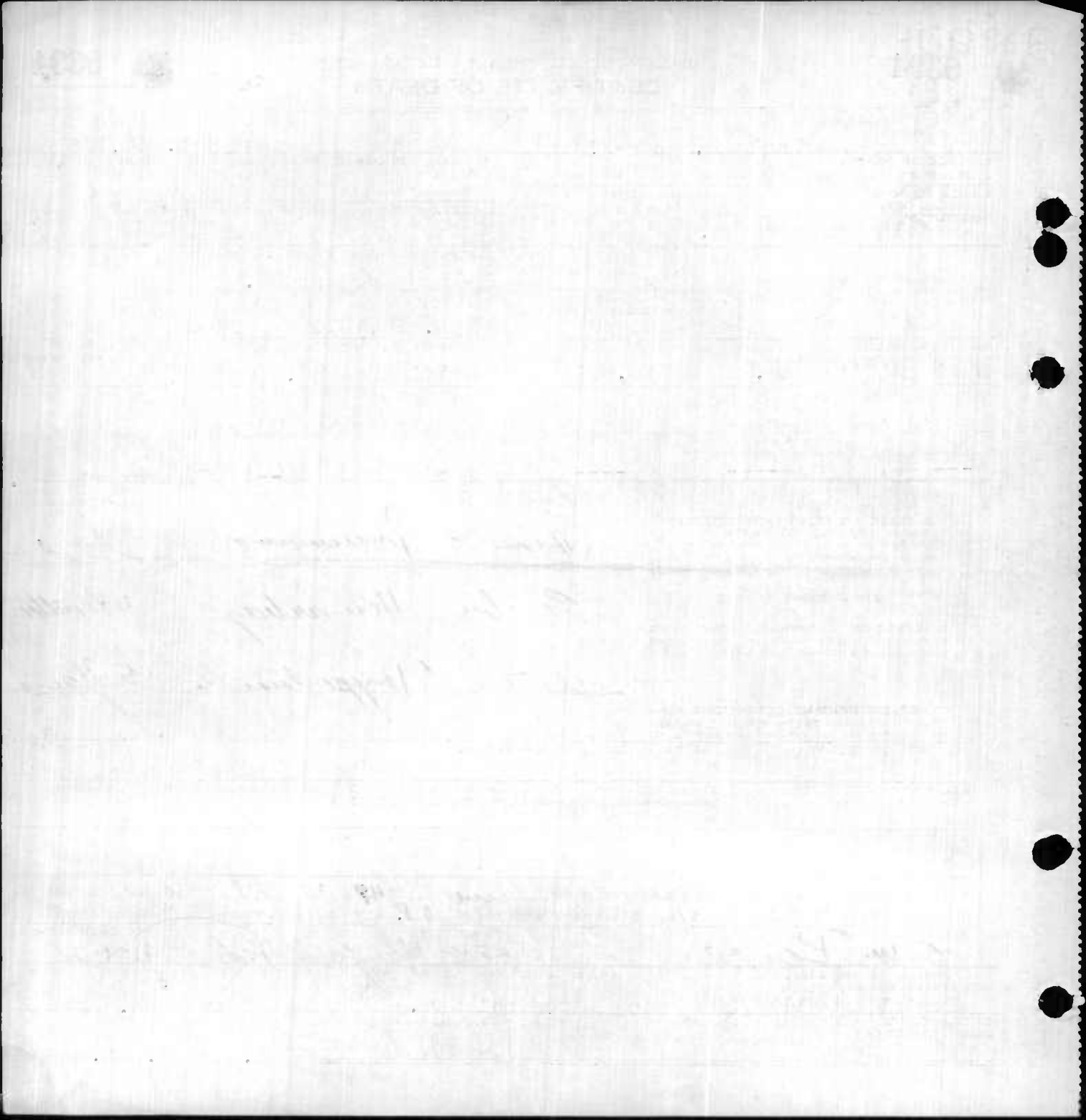
ALBANY:
JAMES C. CLARK,
ATTORNEY GENERAL.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9394**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Michael J. McGrath		2. DATE OF DEATH Oct. 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION 4415 Harcourt Rd.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 4415 Harcourt Rd.			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 20, 1874	9. AGE (In years last birthday) 76	10. Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (City Eng.)		10B. KIND OF BUSINESS OR INDUSTRY Balto, City		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME William McGrath		14. MOTHER'S MAIDEN NAME Elizabeth McGugan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS Marie McGrath--4415 Harcourt Rd.	

18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Broncho Pneumonia DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Cerebral Hemorrhage DUE TO		4 Months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Arterial Hypertension		5 Years
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from June , 1948 to 10-30 , 1950, that I last saw the deceased alive on 10-30 , 1950, and that death occurred at 10 P. m. , from the causes and on the date stated above.				
23A. SIGNATURE E. W. Pearce		23B. ADDRESS M. D. 4508 Hanford Rd.		23C. DATE SIGNED 11-1-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/3/50	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	24D. LOCATION (City, town, or county) (State) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 2 - 1950	REGISTRAR'S SIGNATURE Antonia J. Williams, M.D.	25. FUNERAL DIRECTOR ADDRESS John W. Moran 3000 E. Balto. St. NB		



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 9395

BIRTH NO. 50-23132

1. NAME OF DECEASED
(Type or Print)

BABY BOY HARANSKY

2. DATE
OF
DEATH

10/30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2100 Pressbury St. # 17

c. Length of stay in Baltimore

2 hrs.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

10/30/50

9. AGE (In years
last birthday)11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

2

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Herman Haransky

14. MOTHER'S MAIDEN NAME

Rose Stein

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Herman Haransky, 2100 Pressbury St. # 17

18. 755x

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Internal malformation.

DUE TO

Bilet. hare-lip

ANTECEDENT CAUSES

(B)

Cleft palate

DUE TO

Claw rt. hand

Deformed lt. finger

(C)

Deformed penis

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 10/30/1950, to 10/30/1950 that I last saw the
deceased alive on 10/30/1950, and that death occurred at 4:00 AM from the causes and on the date stated above.

23A. SIGNATURE

Lee N. Kastner

M. D.

23B. ADDRESS

96 Sinai Hosp.

23C. DATE SIGNED

10/30/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Collector of Health

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF REGISTRAR

10 1015

10 1015

10

10

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9396

BIRTH NO. 58-23157

1. NAME OF DECEASED (Type or Print) <u>Ervin Larry Hines</u>			2. DATE OF DEATH <u>Oct 28, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto- 17</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hospital for the Women of Md</u>			C. CITY OR TOWN (If outside corporate limits, write FULL and give township) <u>Balto- 17</u>		
C. Length of stay in Baltimore Yrs. <u>47</u> Mos. <u>47</u> Days <u>47</u>			D. STREET ADDRESS (If rural, give location) <u>1519 Park Av.</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>—</u>	8. DATE OF BIRTH <u>Oct 26 1950</u>	9. AGE (in years; last birthday) <u>1</u> <u>11</u> <u>37</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
11. FATHER'S NAME <u>Edward Ervin Hines</u>			12. MOTHER'S MAIDEN NAME <u>Evelyn Steele</u>		
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>			14. SOCIAL SECURITY NO. <u>—</u>		
15. INFORMANT <u>Edward Ervin Hines</u>			ADDRESS <u>Hines</u>		

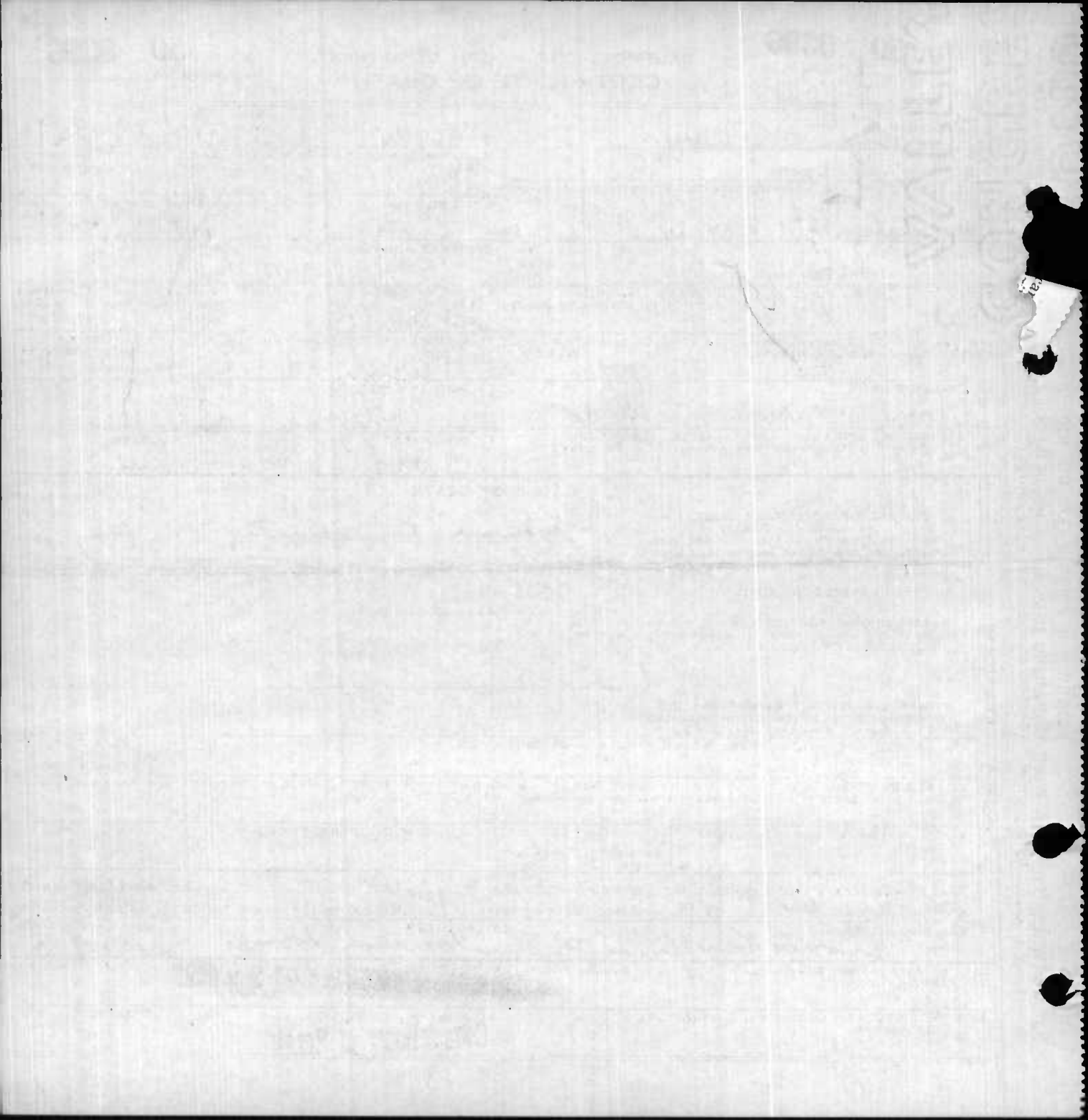
18. <u>776x</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>Extreme Prematurity</u> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <u>1 day 11 1/2 hrs.</u>
	(B) <u>—</u> DUE TO	
	(C) <u>—</u>	

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from <u>Oct 26</u> , 19 <u>50</u> , to <u>Oct 28</u> , 19 <u>50</u> ; that I last saw the deceased alive on <u>Oct 28</u> , 19 <u>50</u> , and that death occurred at <u>10th</u> A.m., from the causes and on the date stated above.		23A. SIGNATURE <u>Jerome Kaufman</u> M. D.	23B. ADDRESS <u>Woman's Hosp.</u>	23C. DATE SIGNED <u>10/28/50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY (If in Baltimore City, give location, or county) (State) <u>JOHN HOPKINS MEDICAL SCHOOL</u> <u>OCT 30 1950</u>		
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR <u>Commissioner of Health</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be applied. The correct age is especially important. Physicians: please write the causes of death clearly and in full.



F 430

50 9397

(209612)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 9397

BIRTH NO. 50-20129		1. NAME OF DECEASED (Type or Print) Baby Boy Fleet		2. DATE OF DEATH September 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 23 The Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore		6-05	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1508 Orleans Street			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH September 19, 1950	9. AGE (In years, last birthday) 15	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Nathaniel Dunlop		14. MOTHER'S MAIDEN NAME Evelyn Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. 776x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Prematurity DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sep. 19, 1950 to Sep. 19, 1950, that I last saw the deceased alive on Sep. 19, 1950, and that death occurred at 5:57 P. M., from the causes and on the date stated above.					
23A. SIGNATURE Bruce R. Smith		23B. ADDRESS 601 N. Broadway		23C. DATE SIGNED 9-24-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Hospital Disposal	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR NOV 3 - 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		9395	

3008 (C)

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other		20. Signature of other	
21. Signature of other		22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9398

Registered No. _____

NO.

NAME OF DECEASED
(Type or Print)

Emma Ullrich

2. DATE
OF
DEATH

10/31/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

539 Pontiac Ave.

D. STREET ADDRESS (If rural, give location)
539 Pontiac Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Nov. 6, 1871

9. AGE (In years last birthday)

78

10 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

-- Grosse

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. Hildegard Rossman 539 Pontiac Ave.

18. **420.0**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Arterio sclerotic heart disease**

**1 year
10 mos.**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **General arterio sclerosis**

?

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **12/24/48** to **10/31/50**, 19__, that I last saw the deceased alive on **10/31/1950** and that death occurred at ____ m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Deilee

M. D.

23B. ADDRESS

1226 Hanover St.

23C. DATE SIGNED

11/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 3, '50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county) (State)

Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC. 715 Light St.

NOV 3 - 1950

VS 150

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9399**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NOAH DUTTON

2. DATE
OF
DEATH

October 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

414 W. Franklin Street

C. Length of stay in Baltimore

32 Years

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 3, 1896

9. AGE (In years
last birthday)

54 53

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Ash Hoister

10B. KIND OF BUSINESS OR
INDUSTRY

B&O R. R.

11. BIRTHPLACE (State or foreign country)

Poplar Springs Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Cecil C. Dutton

14. MOTHER'S MAIDEN NAME

Mamie Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War #1

16. SOCIAL
SECURITY NO.

217-01-0020

17. INFORMANT

ADDRESS 414

Miss Mildred Dutton W. Franklin

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley S. Durlacher M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Oct. 31, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

Balto. National

24D. LOCATION (City, town, or county)

Catonsville Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 3 - 1950

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Holland Funeral Home

ADDRESS

VS 151

970 50 1631 Druid Hill Ave.

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20 1938

20 1938

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of burial place		18. Signature of interment		19. Signature of burial place		20. Signature of interment	
21. Signature of burial place		22. Signature of interment		23. Signature of burial place		24. Signature of interment	
25. Signature of burial place		26. Signature of interment		27. Signature of burial place		28. Signature of interment	
29. Signature of burial place		30. Signature of interment		31. Signature of burial place		32. Signature of interment	
33. Signature of burial place		34. Signature of interment		35. Signature of burial place		36. Signature of interment	
37. Signature of burial place		38. Signature of interment		39. Signature of burial place		40. Signature of interment	
41. Signature of burial place		42. Signature of interment		43. Signature of burial place		44. Signature of interment	
45. Signature of burial place		46. Signature of interment		47. Signature of burial place		48. Signature of interment	
49. Signature of burial place		50. Signature of interment		51. Signature of burial place		52. Signature of interment	
53. Signature of burial place		54. Signature of interment		55. Signature of burial place		56. Signature of interment	
57. Signature of burial place		58. Signature of interment		59. Signature of burial place		60. Signature of interment	
61. Signature of burial place		62. Signature of interment		63. Signature of burial place		64. Signature of interment	
65. Signature of burial place		66. Signature of interment		67. Signature of burial place		68. Signature of interment	
69. Signature of burial place		70. Signature of interment		71. Signature of burial place		72. Signature of interment	
73. Signature of burial place		74. Signature of interment		75. Signature of burial place		76. Signature of interment	
77. Signature of burial place		78. Signature of interment		79. Signature of burial place		80. Signature of interment	
81. Signature of burial place		82. Signature of interment		83. Signature of burial place		84. Signature of interment	
85. Signature of burial place		86. Signature of interment		87. Signature of burial place		88. Signature of interment	
89. Signature of burial place		90. Signature of interment		91. Signature of burial place		92. Signature of interment	
93. Signature of burial place		94. Signature of interment		95. Signature of burial place		96. Signature of interment	
97. Signature of burial place		98. Signature of interment		99. Signature of burial place		100. Signature of interment	

J-520
50 9400
MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9400

1. NAME OF DECEASED (Type or Print) Izette Peaco Jones			2. DATE OF DEATH Oct. 31, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md. D. STREET ADDRESS (If rural, give location) 543 W. Hoffman St.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 543 W. Hoffman St.			c. Length of stay in Baltimore 54 Years		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 7, 1896	9. AGE (in years last birthday) 54	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Richmond Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME James Peaco			14. MOTHER'S MAIDEN NAME Sarah Gilpin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT (Mrs) Hattie Johnson ADDRESS 543 W. Hoffman St.		
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) cerebral thrombosis DUE TO ANTECEDENT CAUSES (B) arteriosclerosis, generalized DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 46 Years 3+ years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1 Sept. , 1950, to 31 Oct. , 1950, that I last saw the deceased alive on 31 Oct. , 1950, and that death occurred at 1238 m., from the causes and on the date stated above.					
23A. SIGNATURE James D. Carr M. D.		23B. ADDRESS 1427 Madison Ave		23C. DATE SIGNED 11-2-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 4, 1950		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) Baltimore Maryland		25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS			
DATE RECEIVED BY LOCAL REGISTRAR NOV 3 - 1950		REGISTRAR'S SIGNATURE Huntington Williams		25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS	

VS 150

1631 Druid Hill Ave.

83B

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CERTIFICATE OF DEATH

50 9401

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) JOANNE JANE GROSS		2. DATE OF DEATH November 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 56 yrs		D. STREET ADDRESS (If rural, give location) 1019 N. Mount Street	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10B. KIND OF BUSINESS OR INDUSTRY Domestic	9. AGE (In years last birthday) 64
11. BIRTHPLACE (State or foreign country) Cuba Co - md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Moses Torne		14. MOTHER'S MAIDEN NAME Jane Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Elmer Robinson	
18. 422.1		ADDRESS 1019 Mount St	

18. 422.1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Arteriosclerotic cardiovascular disease		
ANTECEDENT CAUSES		(B) _____		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (a. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an <u>Insp. & Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .				
23A. SIGNATURE <i>Stanley B. Denecker</i> M.D.		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 11-2-50
24A. BURIAL, CREMA-TION, REMOVAL (Specify) Burial	24B. DATE 11/5/50	24C. NAME OF CEMETERY OR CREMATORY Brooks Chapel	24D. LOCATION (City, town, or county) (State) Prince Frederick Md	
DATE RECEIVED BY LOCAL REGISTRAR NOV 3 - 1950		25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc ADDRESS 927 N. Mount St.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9402

Registered No. _____

BIRTH NO. 50 9402

1. NAME OF DECEASED (Type or Print) <u>Elizabeth Rebecca Mitchell</u>			2. DATE OF DEATH <u>12.2.50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>2101 N. Cold Spring</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) STATE <u>md.</u> B. COUNTY <u>Balto.</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Col. Spring Nursery</u>			CITY OR TOWN <u>Balto.</u> (If outside corporate limits, give town and township)		
c. Length of stay in Baltimore <u>70 yrs</u>			D. STREET ADDRESS (If rural, give location) <u>1808 Eagle St.</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1880</u>	9. AGE (in years; last birthday) <u>70 yrs.</u>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Balto., Co., md.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>
13. FATHER'S NAME <u>Nathan Smith</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT ADDRESS <u>Jessie Bailey 1808-Eagle St</u>		

18. 334X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 21 1950 to Nov. 2 1950 that I last saw the deceased alive on Nov. 2 1950 and that death occurred at 9 a m., from my causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

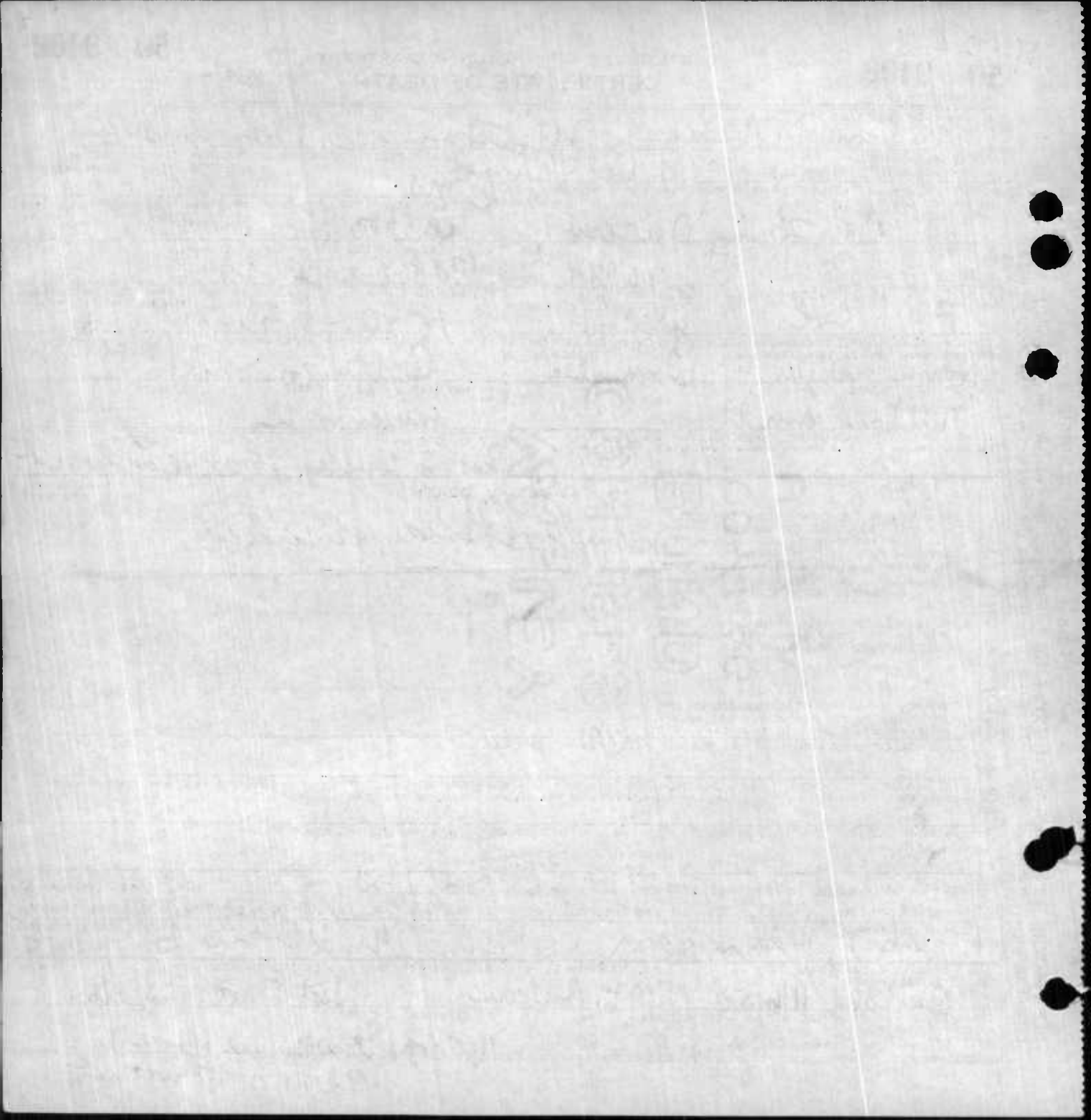
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9403
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALTA SIMON

2. DATE
OF
DEATH

November 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE New Jersey

B. COUNTY

V-37

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

600 6200 Biltmore Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
New Brunswick

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

6 weeks

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
widow

8. DATE OF BIRTH

December 10, 1859

9. AGE (In years
last birthday)

90

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

unknown

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Wolf

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Charles Simon, 6200 Biltmore Ave.

18. 420.0

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Cerebral Vasc. Accident
Probably HemorrhageINTERVAL BETWEEN
ONSET AND DEATH

12 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

generalized arteriosclerosis
arteriosclerosis/Heart
Disease & Hypertension

20 years

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

5 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1950, to Nov 2, 1950, that I last saw the
deceased alive on Nov 2, 1950, and that death occurred at 11:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Leonard Wallenstein

M. D.

23B. ADDRESS

878 W 36th St

23C. DATE SIGNED

Nov 3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11-5-1950

24C. NAME OF CEMETERY OR CREMATORY

Washington Cem.

24D. LOCATION (City, town, or county)

Deans, New Jersey

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 3 - 1950

REGISTRAR'S SIGNATURE

Washington Millican, M.D.

25. FUNERAL DIRECTOR

Wm. J. Fickert, Balto Ind.

ADDRESS

3012 13

RECEIVED FOR THE SECRETARY OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

100



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LENA HERR

2. DATE
OF
DEATH

11-3-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

Md

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION

49 Doctors Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4658 Park Heights Ave

C. Length of stay in Baltimore

50

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

9. AGE (In years last birthday)

69 75

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Gershon

14. MOTHER'S MAIDEN NAME

Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Max Herr

ADDRESS

- Same

18. 331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Acute Cerebral Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

General Arteriosclerosis

(C) DUE TO

Malignant Hypertension

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/24/49, to 11/2, 1950, that I last saw the deceased alive on 11/2, 1950, and that death occurred at 11/2, 1950, from the causes and on the date stated above.

23A. SIGNATURE

A. H. Hornstein

23B. ADDRESS

204 E. Biddle St

23C. DATE SIGNED

11/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Buried

24B. DATE

11/5/1950

24C. NAME OF CEMETERY OR CREMATORY

Wash. Blvd

24D. LOCATION (City, town, or county)

Bald

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis Inc - 2100 Eutaw Pl.

ADDRESS

NOV 3 - 1950

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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B-452

50 9405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9405

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)Miss S. DNEYA HALL
BLANCHARD2. DATE
OF
DEATH

11/1/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

CHURCH HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

CHURCH HOME

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

6-05

c. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

BROADWAY + FARMOUNT

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

DEC 1 1859

9. AGE (In years last birthday)

90 91

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

WYATT BLANCHARD

14. MOTHER'S MAIDEN NAME

ANNA HALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Record

18. 442X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

HYPOSTATIC PNEUMONIA
CORD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

COMBINED DEGENERATION OF
PERNICIOUS ANEMIA

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

GEN. ARTERIOSCLEROSIS

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1948, to 11/1, 1950, that I last saw the deceased alive on 10/31, 1950, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Donald W. Mink

23B. ADDRESS

3009 Eversong Ave Baltimore, Md

23C. DATE SIGNED

11/1/50

24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

Nov 3 1950

24C. NAME OF CEMETERY OR CREMATORY

Old St Pauls

24D. LOCATION (City, town, or county)

Balt. Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

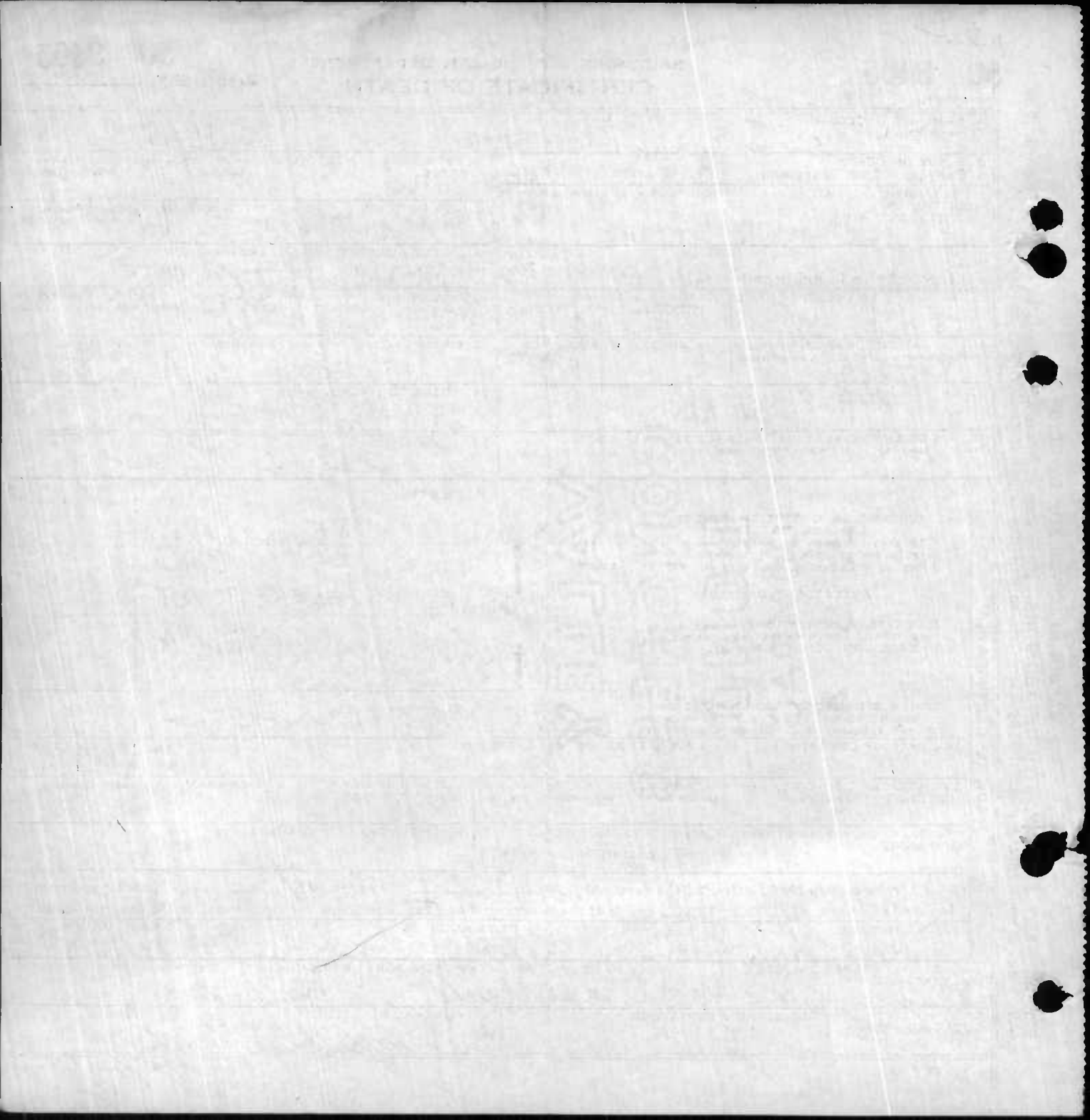
William W. Williams

25. FUNERAL DIRECTOR

Henry H. Jenkins & Sons Co

ADDRESS

490 York Rd.



C-200
50 9406BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9406

BIRTH NO.			1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
			ARLENE D. COOK			10/31/50		
3. PLACE OF DEATH:						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
A. Baltimore City, Maryland 1437 Sumwalt Ct.						A. STATE Md.		
B. FULL NAME OF HOSPITAL OR INSTITUTION						C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
						Baltimore		
c. Length of stay in Baltimore Life						D. STREET ADDRESS (If rural, give location)		
						1437 Sumwalt Court		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Year Months: Days
F	W	S		10/11/1931		19		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
None						Baltimore		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Orville Cook				Naomi S. Flemister				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No						Family - Same		
18. 193X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) Astrocytoma of 4th ventricle and cerebellum								?
DUE TO								
18. ANTECEDENT CAUSES						(B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.						DUE TO		
						(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 12/31/49, 19, to 10/31/50 19, that I last saw the deceased alive on 10/31/50, and that death occurred at m., from the causes and on the date stated above.								
23A. SIGNATURE				23B. ADDRESS			23C. DATE SIGNED	
Harry Deibel				1226 Hanover St.			11/2/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)		
B		11/4/50		Holy Cross		Baltimore		
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS		
NOV 3 1950		[Signature]		James L. Deane		- 130 E. Fort Ave.		
VS 150								

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C-452

50 9407

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9407

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NAOMI COLLINS

2. DATE

OF

DEATH October 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1008 W. Fayette Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

November 13, 1889

9. AGE (In years last birthday)

60

H Under 1 Year

Months: Days

H Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joshua Jarvis

14. MOTHER'S MAIDEN NAME

Susie Rogers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Sadie Dizon. 519 W. Hoffman St.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office hldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Quinlan M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

Oct. 31, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial 11-4-1950 Mt. Auburn Cem. Balto. Md.

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

322X

NOV 3 - 1950

Washington Williams, Jr.

Miss Katie R. Williams

Schick St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

50 8107

THE OFFICE OF THE
ATTORNEY GENERAL

50 8107



W 425
30 9408BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9408

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Wilson

2. DATE
OF
DEATH

Oct 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. Dept 2

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Md

19-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1611 Sarah Ann St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

795.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Uremia

INTERVAL BETWEEN
ONSET AND DEATH

?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Unknown and obscure
illness

?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-26-1950 to 10-31-1950 that I last saw the
deceased alive on 10-31-1950 and that death occurred at 3:10 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Victor A. Mc Kusick, M. D.

JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

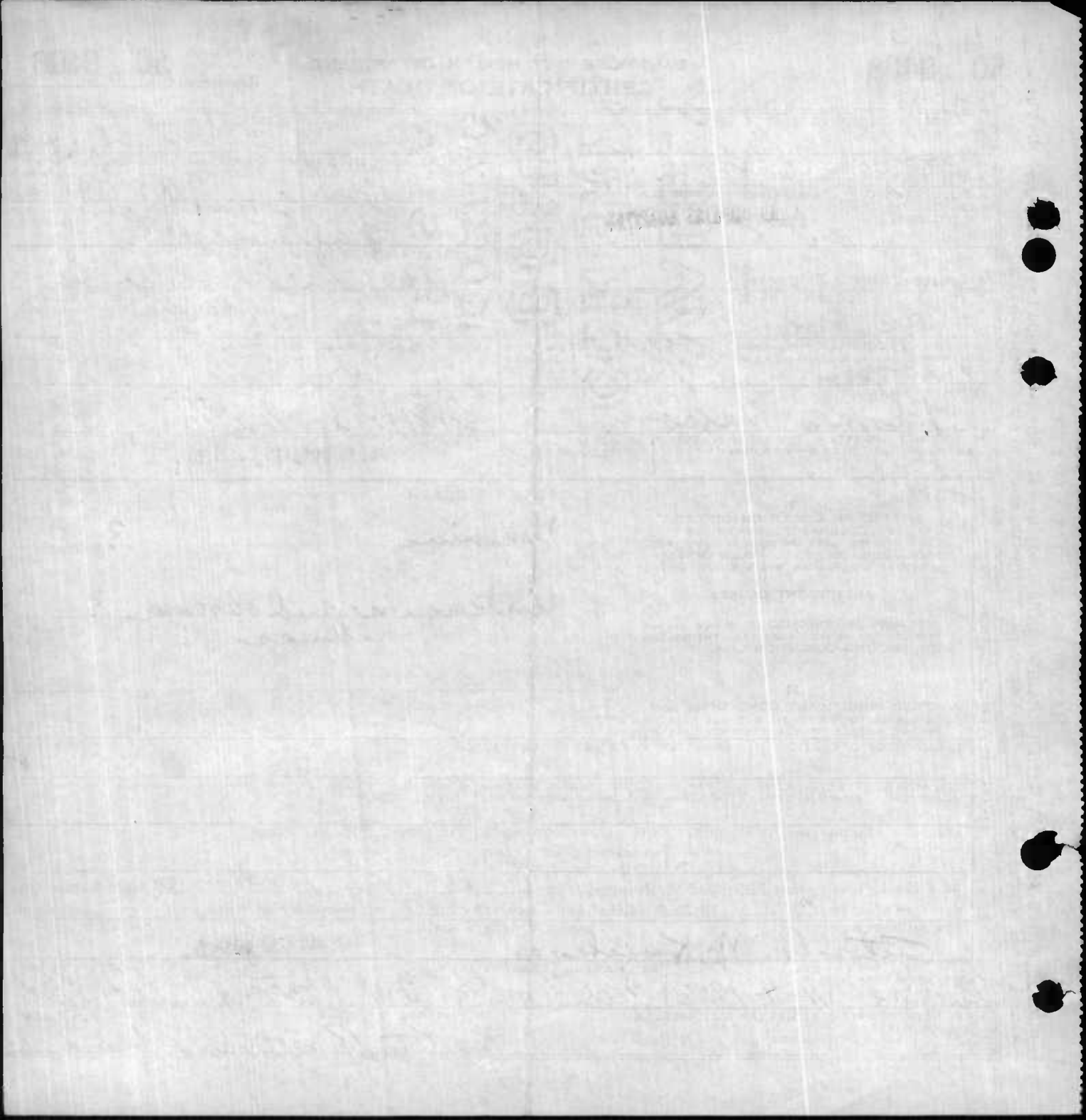
NOV 3 - 1950

Wilmington Williams, Md

Mrs. Kate R. Williams Schwedler

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



B-653
50 9409Elmer Burnette
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9409
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELMER BURNETTE

2. DATE
OF
DEATH

11-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

38 UNIVERSITY HOSPITAL

Yrs.
Mos.
Days

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, give rural and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

611 PIERCE ST.

5. SEX

MA

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1885-4-10 65

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

OLD PAPER COLLECTOR

10B. KIND OF BUSINESS OR
INDUSTRY

SELF

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John Burnette

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

HOSPITAL RECORDS

18. 340.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) MENINGITIS, PNEUMONOCOC

DUE TO

10 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) PNEUMONIA

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from OCT 21, 1950 to NOV 1, 1950 that I last saw the
deceased alive on NOV 1, 1950 and that death occurred at 6:25 PM., from the causes and on the date stated above.

23A. SIGNATURE

John W. Slower M.D.

23B. ADDRESS

211 W. 11th St.

23C. DATE SIGNED

11-2-50

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

11-6-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Balto

(State)

Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Therese J. Williams

25. FUNERAL DIRECTOR

Mrs. Kate R. Williams

ADDRESS

322 N Schuman St

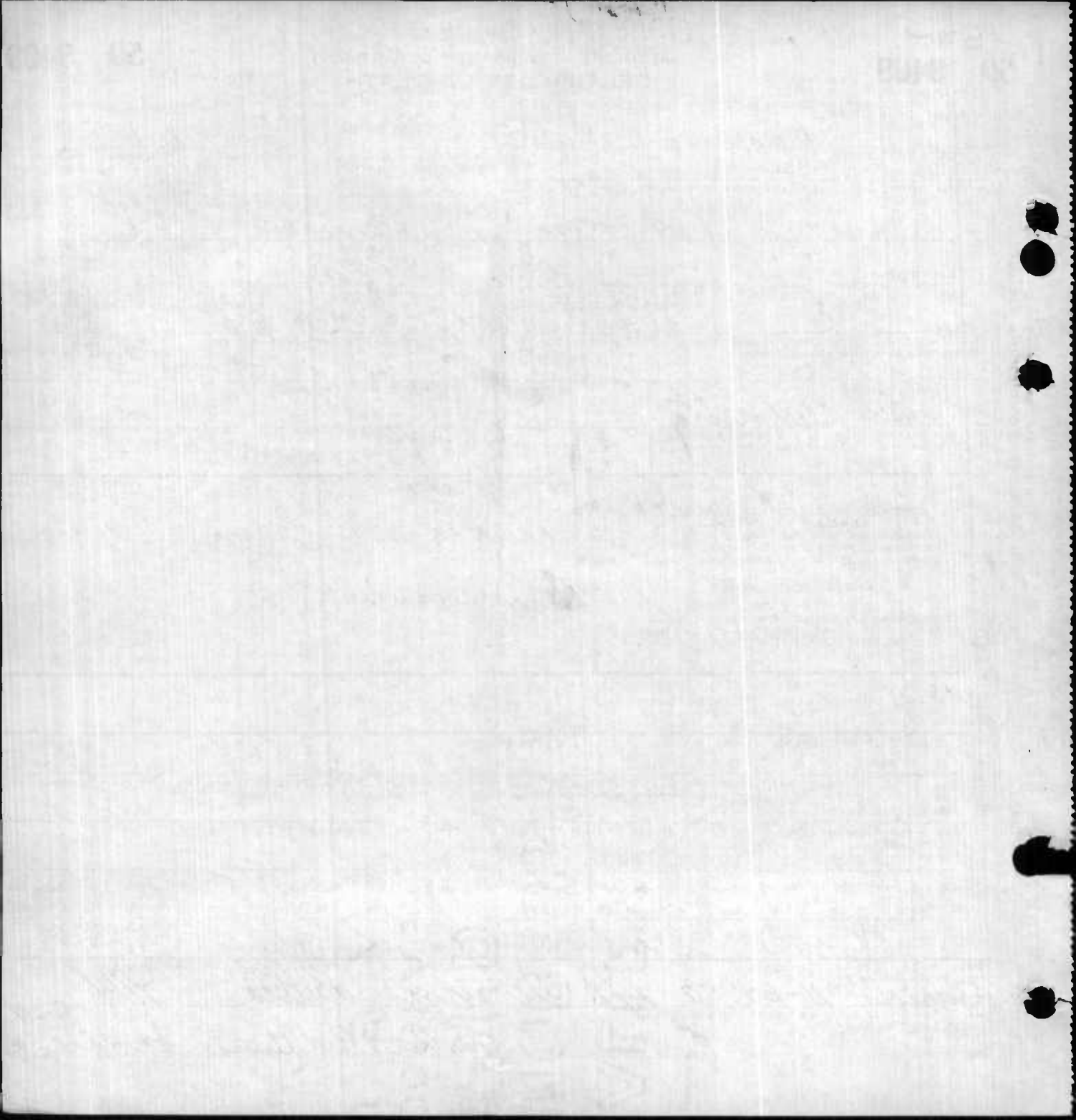
VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9410

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

ETHEL

BENNETT

2. DATE
OF
DEATH

October 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

City.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RHRA, and give township)

Baltimore

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

134 S. Dallas Street

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 22, 1886

9. AGE (In years last birthday)

64

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laundress

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Fairmont Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lennis King

14. MOTHER'S MAIDEN NAME

Mollie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Harry Bennett - 134 S. Dallas St

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Dencosky M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Oct. 31, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-8-50

24C. NAME OF CEMETERY OR CREMATORY

mt Auburn

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams

25. FUNERAL DIRECTOR

W. H. Hulestead - 918 -

ADDRESS

NOV 3 - 1950
VS 151

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9411**N.D. 135286
50 9411

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Leroy Cockrell			2. DATE OF DEATH Nov. 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 22 Years			D. STREET ADDRESS (If rural, give location) 1818 Orleans St.		
5. SEX M	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH Feb. 16, 1911	9. AGE (In years last birthday) 39	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender		10B. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Robert Cockrell			14. MOTHER'S MAIDEN NAME Alabama Parrott		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or on know) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-4188	17. INFORMANT Baltimore City Hospitals Records 4940 Eastern Avenue		

18. 002X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis Far-Advanced DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Pulmonary Tuberculosis Far-Advanced DUE TO 11 Months		
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 1-30 , 19 50 , to 11-1 , 19 50 , that I last saw the deceased alive on 11-1 , 19 50 , and that death occurred at 11.40 pm., from the causes and on the date stated above.					
23A. SIGNATURE J. B. Hogan		23B. ADDRESS Baltimore City Hospitals (Baltimore) 4940 Eastern Avenue	23C. DATE SIGNED 11-2-50		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/50	24C. NAME OF CEMETERY OR CREMATORY AME. Zion Cemetery		24D. LOCATION (City, town, or county) (State) Chester, S. C.
DATE RECEIVED BY LOCAL REGISTRAR NOV 3 - 1950		REGISTRAR'S SIGNATURE W. J. Williams		25. FUNERAL DIRECTOR Charles A. Law 802 Madison Ave.	

50 3111

CERTIFICATE OF DEATH

50 3111



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9412

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED **KATHARINE A. BRADY.**
(Type or Print) **Mrs. Katherine Anna Brady**

2. DATE OF DEATH **November 2, 1950**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION
41 St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
133 S. Linwood Avenue

c. Length of stay in Baltimore **LIFE**
Yrs. _____ Mos. _____ Days _____

5. SEX **Fe.** 6. COLOR OR RACE **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Widowed**

8. DATE OF BIRTH **JULY 19 1895** 9. AGE (In years last birthday) **55**
If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Hwife.** 10B. KIND OF BUSINESS OR INDUSTRY **Own Home**

11. BIRTHPLACE (State or foreign country) **Baltimore, Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **JOHN KOPP**

14. MOTHER'S MAIDEN NAME **MARIE NEUSCHAFER**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **NO** 16. SOCIAL SECURITY NO. **NONE**

17. INFORMANT ADDRESS **JOHN BRADY 133 S LINWOOD AVE.**

18. **203X** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Aplastic Anemia**
DUE TO
(B) **Multiple Myeloma**
DUE TO
(C) _____
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **8/7/**, 19**50**, to **11/2/**, 19**50**, that I last saw the deceased alive on **11/2/**, 19**50**, and that death occurred at **7:40 A.M.** from the causes and on the date stated above.

23A. SIGNATURE **B. B. Weber** 23B. ADDRESS **1100 N. Caroline Street** 23C. DATE SIGNED **11/2/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 24B. DATE **NOV 4 1950** 24C. NAME OF CEMETERY OR CREMATORY **HOLY REDEEMER CEM** 24D. LOCATION (City, town, or county) (State) **4430 BELAIR RD MD**

DATE RECEIVED BY LOCAL REGISTRAR **NOV 3 1950** REGISTRAR'S SIGNATURE **W. H. Williams** 25. FUNERAL DIRECTOR ADDRESS **Dippel Bros 1800 E LOMBARD ST**

MARGIN RESERVED FOR BINDING
PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B

400

50 9413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9413

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James I Bailey

2. DATE
OF
DEATH

Nov 2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

207 N. LINWOOD AVE.

C. CITY OR TOWN (If outside corporate limits, write FULL and give township)

Baltimore

6-01

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

207 N. LINWOOD AVE

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 30/1899

9. AGE (In years
last birthday)

71

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

K K Engineer

10B. KIND OF BUSINESS OR
INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James W Bailey

14. MOTHER'S MAIDEN NAME

Magdalena Geph

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Maurice Bailey 207 N. Linwood Ave

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Hemorrhage

Oct 29/50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis

10 yrs

(C) Hypertensive Arterio-sclerosis -
Vascular disease

10 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 29, 1950, to Nov. 1st, 1950, that I last saw the deceased alive on Nov 1st, 1950, and that death occurred at 3 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph H Zuerler

M. O.

23B. ADDRESS

2318 Entar Place

23C. DATE SIGNED

11/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Willie's Funeral Home

ADDRESS

8 Orleans St

VS 150

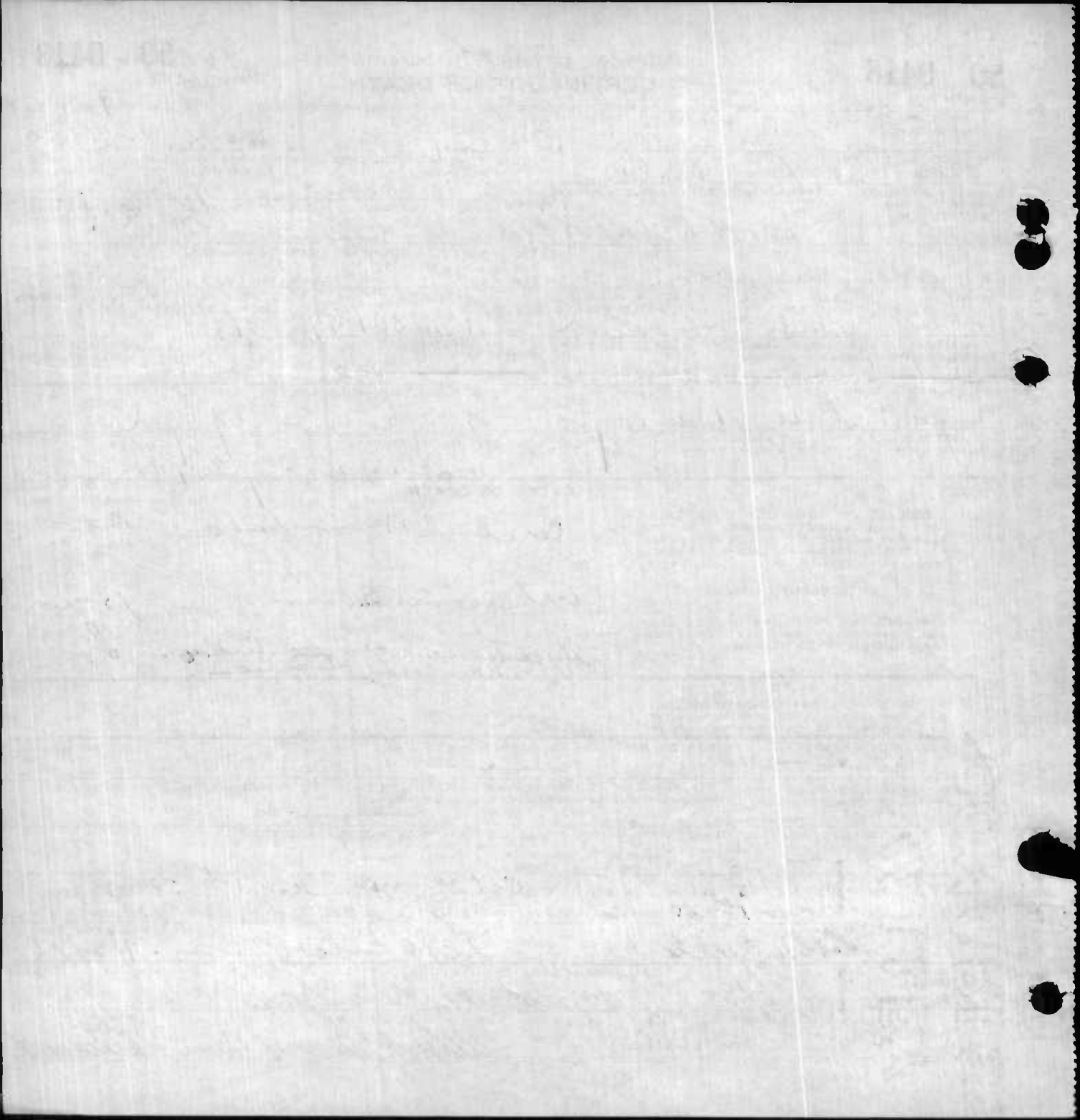
541 50

927

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly supplied. The correct age is especially important. Physicians: please write the causes of death.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9414

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Mary L. Daneker</i>			2. DATE OF DEATH <i>11-1-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>2628 Cecil Ave.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Dec. 6 - 1810</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>na.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Thaddeus A. Byrd</i>			14. MOTHER'S MAIDEN NAME <i>Sallie Satchell</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

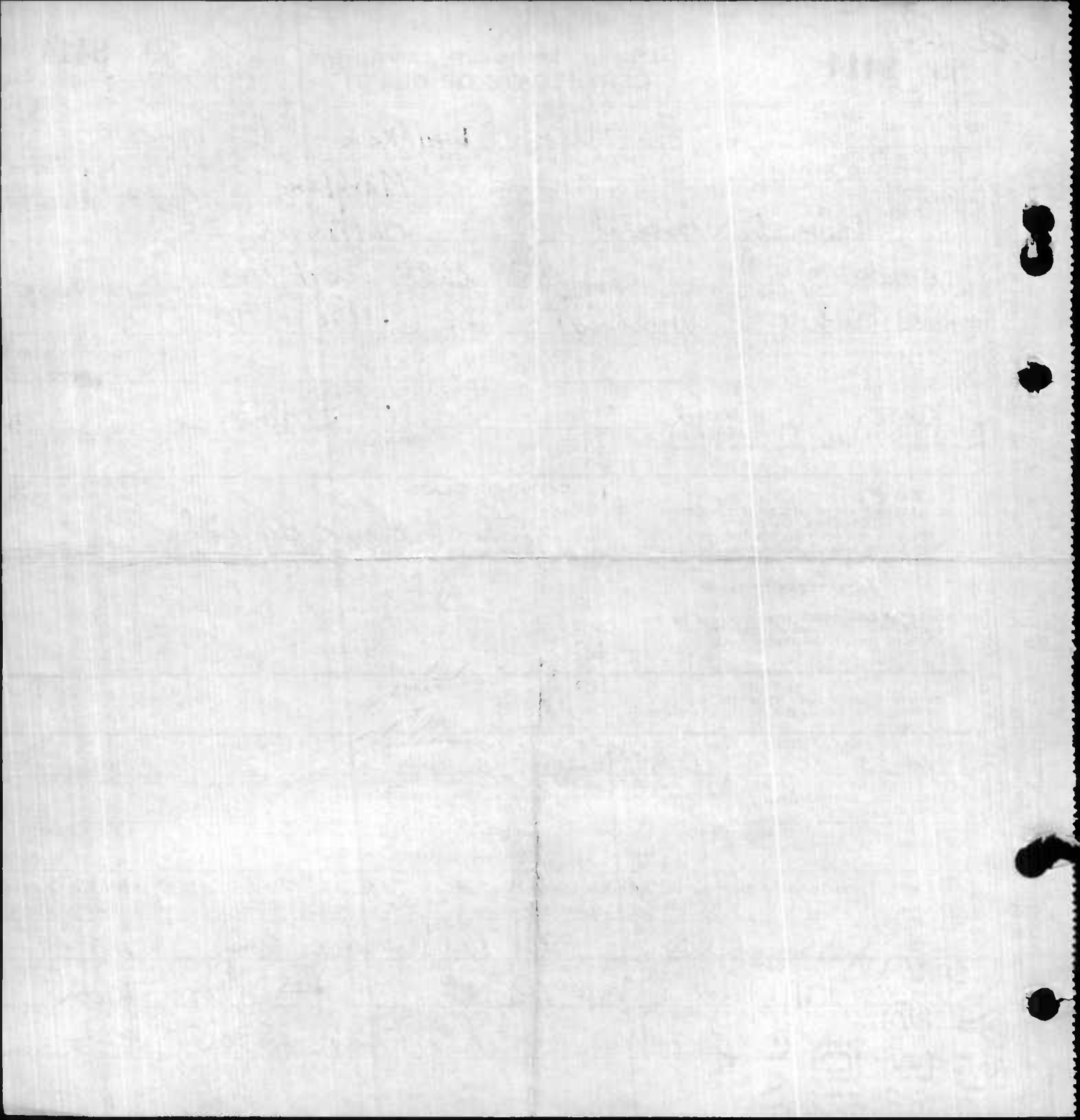
MEDICAL CERTIFICATION	18. <i>584x</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES		(A) <i>operation for chronic cholecystitis</i> DUE TO		
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>senility</i> DUE TO		
			(C) <i>cardiac failure</i>		
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
	19A. DATE OF OPERATION <i>10-22-50</i>		19B. MAJOR FINDINGS OF OPERATION <i>choledolithiasis = cholecystitis</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
	21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
	22. I hereby certify that I attended the deceased from <i>10-20</i> , 19 <i>50</i> , to <i>11-1</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11-1</i> , 19 <i>50</i> and that death occurred at <i>5:15 a.m.</i> , from the causes and on the date stated above.				
	23A. SIGNATURE <i>E. J. Broadbent</i>		23B. ADDRESS <i>University Ave.</i>		23C. DATE SIGNED <i>11-1-50</i>
	24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11/6/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mr. Olivet</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
	DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 3 - 1950</i>		REGISTRAR'S SIGNATURE <i>William H. ...</i>		25. FUNERAL DIRECTOR ADDRESS <i>L. J. Luck 5305 Bayford</i>

VS 150

126

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



325
N.D. - 142960
50 9415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9415
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alice Southcomb			2. DATE OF DEATH 11-1-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 6104 Fair Oaks Ave		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 29, 1860	9. AGE (In years last birthday) 90	H Under 1 Year Months: Days: H Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Peter W. Southcomb			14. MOTHER'S MAIDEN NAME Theodate Pope Longrove		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Baltimore City Hospitals Records; 4940 Eastern Avenue	

18. 170X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Sarcoma, left breast, Advanced DUE TO (A) Sarcoma, left breast, Advanced (B) (C) INTERVAL BETWEEN ONSET AND DEATH 15 years					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 11-1-50		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-30 , 19 50 , to 11-1-50 , 19 50 , that I last saw the deceased alive on 11-1-50 , 19 50 , and that death occurred at 2:45 PM , from the causes and on the date stated above.					
23A. SIGNATURE R. Boyer		23B. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue		23C. DATE SIGNED 11-2-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/50		24C. NAME OF CEMETERY OR CREMATORY Friends Burial	
24D. LOCATION (City, town, or county) (State) Baltimore Md		24E. NAME OF CEMETERY OR CREMATORY Friends Burial		24F. LOCATION (City, town, or county) (State) Baltimore Md	
DATE RECEIVED BY LOCAL REGISTRAR NOV 3 - 1950		REGISTRAR'S SIGNATURE William M. ...		25. FUNERAL DIRECTOR L. J. ...	
VS 150		ADDRESS 5305 Harford Rd			

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9416

Registered No.

BIRTH NO. 50-23360

1. NAME OF DECEASED
(Type or Print)

Baby Girl Rutledge

2. DATE
OF
DEATH

1/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

42 Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River

c. Length of stay in Baltimore

1.50

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

18 Cowl Ct.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/31/50

9. AGE (In years
last birthday)It Under 1 Year
Months: Days
It Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. City Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul E. Rutledge

14. MOTHER'S MAIDEN NAME

Hilda Hewitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

P.E. Rutledge 18 Cowl Court
Middle River

ADDRESS

18.

776X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Prematurity (27 weeks gestation)

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 11/2/50, 19__, to 11/2/50, 19__, that I last saw the
deceased alive on 11/2/50, 19__, and that death occurred at 3:20 P m., from the causes and on the date stated above.

23A. SIGNATURE

L. N. Koster

M. O.

23B. ADDRESS

% Sinai Hosp

23C. DATE SIGNED

11/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial

11/4/50

Parkwood

Balto. Md.

NOV 3 - 1950

Washington Williams

Farrar Funeral Home

7401 Belair Rd.

3110

31

RECEIVED THE HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3110

31

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9417

Registered No. 50-9417

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Isabel Virginia Cromwell

2. DATE OF DEATH
Nov. 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3735 S. Hanover St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3735 S. Hanover St.

C. Length of stay in Baltimore

12 yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

April 5, 1880

9. AGE (In years last birthday)

70

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

restaurant

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin T. Ray

14. MOTHER'S MAIDEN NAME

Virginia Phelps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT ADDRESS
Dorothy Cromwell-3735 S. Hanover St.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation

DUE TO

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic cardiovascular disease

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 11-8-, 1949, to 11-2-, 1950 that I last saw the deceased alive on 11-2, 1950, and that death occurred at 1:00 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Bobby L. Jones

23B. ADDRESS

Glen Burnie Md

23C. DATE SIGNED

11/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

11-6-50

Lorraine Cem.

Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

11-3-50

Huntington Williams, M.D.

Wm J. Ticker & Sons-Balto., Md.

VS 150

7906 M

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE

OF

THE

THE

THE

THE

THE

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THE

THE

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9418

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JAMES WESLEY MAHANEY

2. DATE OF DEATH Nov. 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3810 Reisterstown Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3810 Reisterstown Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
widowed

8. DATE OF BIRTH

Oct. 18, 1897

9. AGE (in years last birthday)

53

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY

Fallsway Spring Co
AUTO SPRING CO

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Henry Mahaney

14. MOTHER'S MAIDEN NAME

Sedonia Sank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. Franklin A. Dugan 5306 Morello Rd.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

(A) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

4 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1950 to Nov 1, 1950 that I last saw the deceased alive on Nov 1, 1950 and that death occurred at 10:15 AM, from the causes and on the date stated above.

23A. SIGNATURE

W. J. Kolman

M. D.

23B. ADDRESS

3700 Park Heights

23C. DATE SIGNED

Nov 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/4/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. J. Kolman

25. FUNERAL DIRECTOR

Wm. J. Lickner & Sons - Co. 94a

ADDRESS

NOV 3 - 1950

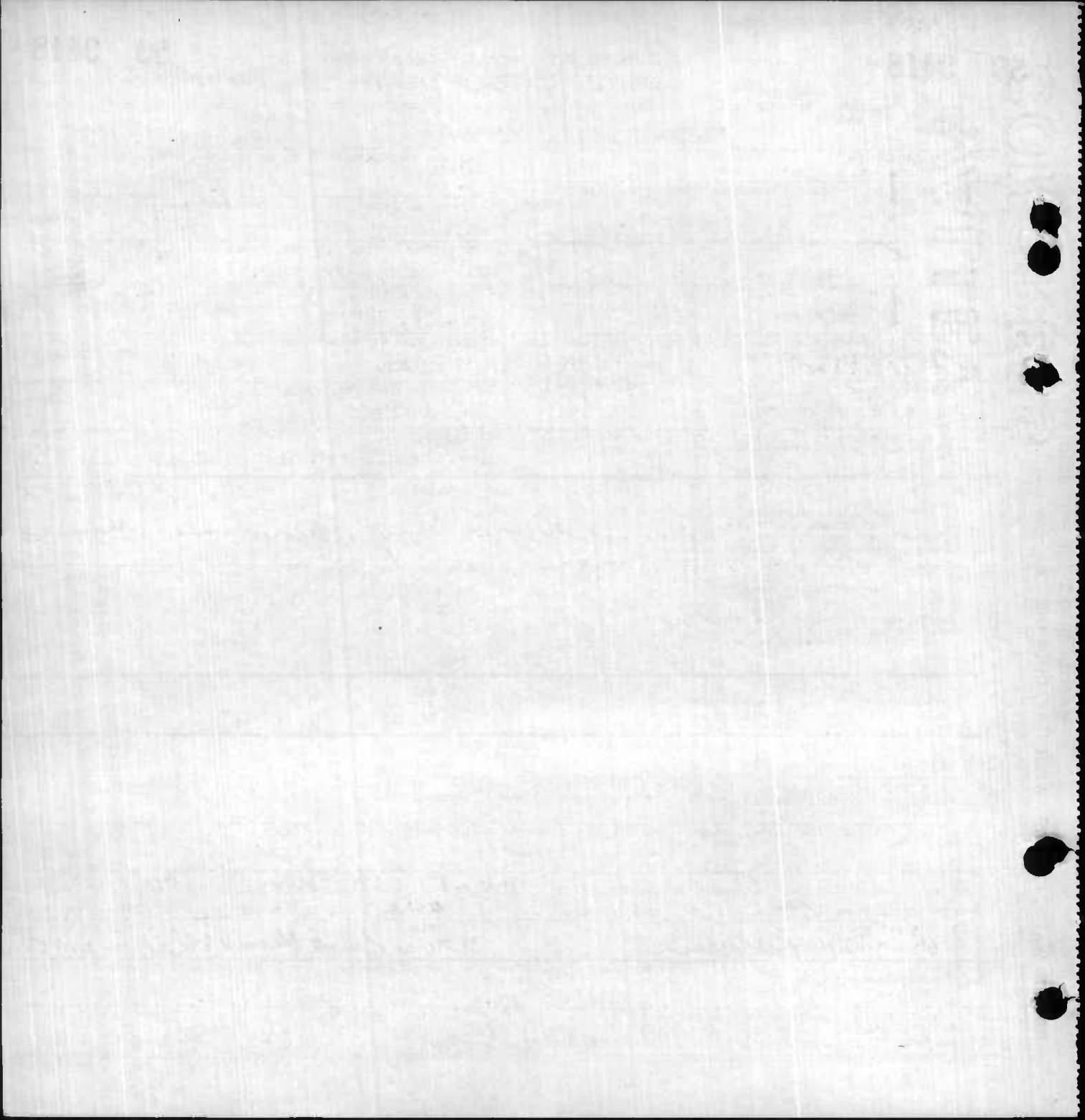
VS 150

4903D

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9419

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES FRANKLIN TAYLOR

2. DATE
OF
DEATH

November 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1301 N. Gilmor Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1904

9. AGE (In years
last birthday)

46

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HUCKSTER

10B. KIND OF BUSINESS OR
INDUSTRY

Fish market

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Taylor

14. MOTHER'S MAIDEN NAME

Henrietta Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Chas. Taylor 1144 N. Calhoun St.

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
m. WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William Taylor

23B. CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Nov. 1, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11/5/50

24C. NAME OF CEMETERY OR CREMATORY

Northumberland

24D. LOCATION (City, town, or county)

Northumberland Co. Va.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Taylor

25. FUNERAL DIRECTOR

ADDRESS

Geo. G. Kelson 1303 Presstman St.

NOV 3 - 1950

VS 151

430 6A Geo. G. Kelson

013B

1919

CERTIFICATE OF DEATH

1919



C-6 35

50 9420

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

50 9420

1. NAME OF DECEASED
(Type or Print)

ANNA MARGARET COURTNEY

ANNA

COURTNEY.

2. DATE
OF
DEATH

11-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

35 Church House + Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore.

D. STREET ADDRESS (If rural, give location)

237 N. Milton Ave.

c. Length of stay in Baltimore

life.

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Mr. ~~Widow~~Yrs.
Mos.
Days

8. DATE OF BIRTH

10/17/1893

9. AGE (In years

last birthday)

57

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House-keeper.

10B. KIND OF BUSINESS OR INDUSTRY

at home

13. FATHER'S NAME

~~Warren Dodge~~

Warren Dodge

14. MOTHER'S MAIDEN NAME Mary Nouse

~~Anny Dodge~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT 237 N. Milton Avenue
John W. Courtney

18. 332X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral thrombosis.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Myocardial infarction.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/26/1950 to 11/1/1950, that I last saw the deceased alive on 10/31/1950, and that death occurred at 1 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Emily Moore MD

M. D.

23B. ADDRESS

Church House.

23C. DATE SIGNED

11-1-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11/4/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. J. Williams, MD

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC. ADDRESS
BALTO., 13, MD.

Seay P. Sander.

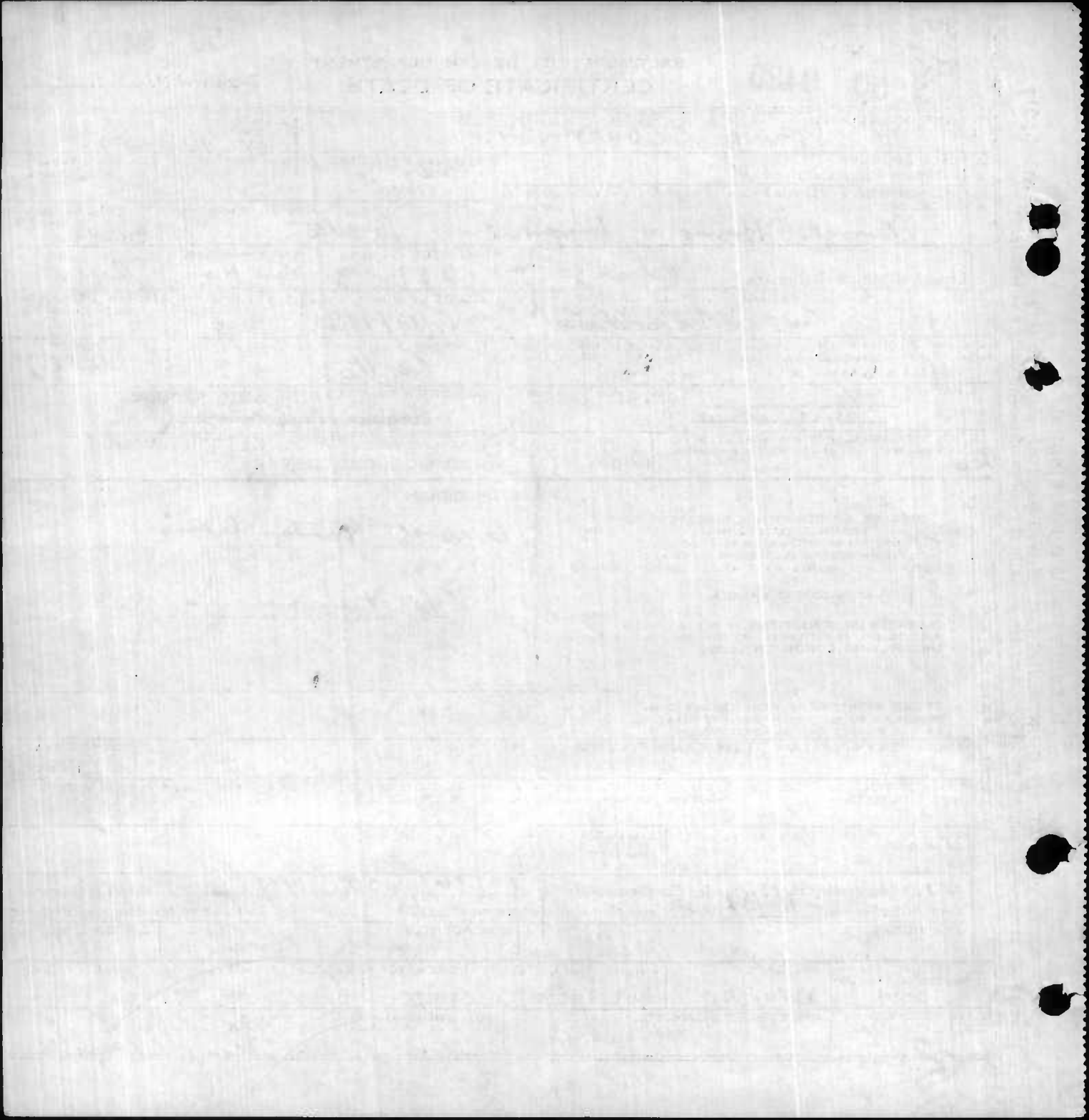
NOV 3 - 1950

VS 150

83B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5-350

50 9421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9421

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES F. STONE

2. DATE
OF
DEATH

Oct. 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

2012 N. Charles Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2012 N. Charles Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

Widower

8. DATE OF BIRTH

Feb. 14, 1879

9. AGE (in years)

71

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fireman & Janitor

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore City

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Wm. L. Stone

14. MOTHER'S MAIDEN NAME

Sarah A. Riley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT ADDRESS

2910 E. Monument Street
Mrs Katherine R. Stone

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

arteriosclerotic Cardio-vascular disease

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 21, 1948 to Oct 31, 1950, that I last saw the deceased alive on Oct 30, 1950, and that death occurred at 2 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Jack J. Surger

M. D.

23B. ADDRESS

506 E North Ave

23C. DATE SIGNED

11-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

11/3/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

FUNERAL DIRECTOR

HENRY SARDER & SONS, INC.

BALTO., 13, MD.

ADDRESS

Denni L. Hill

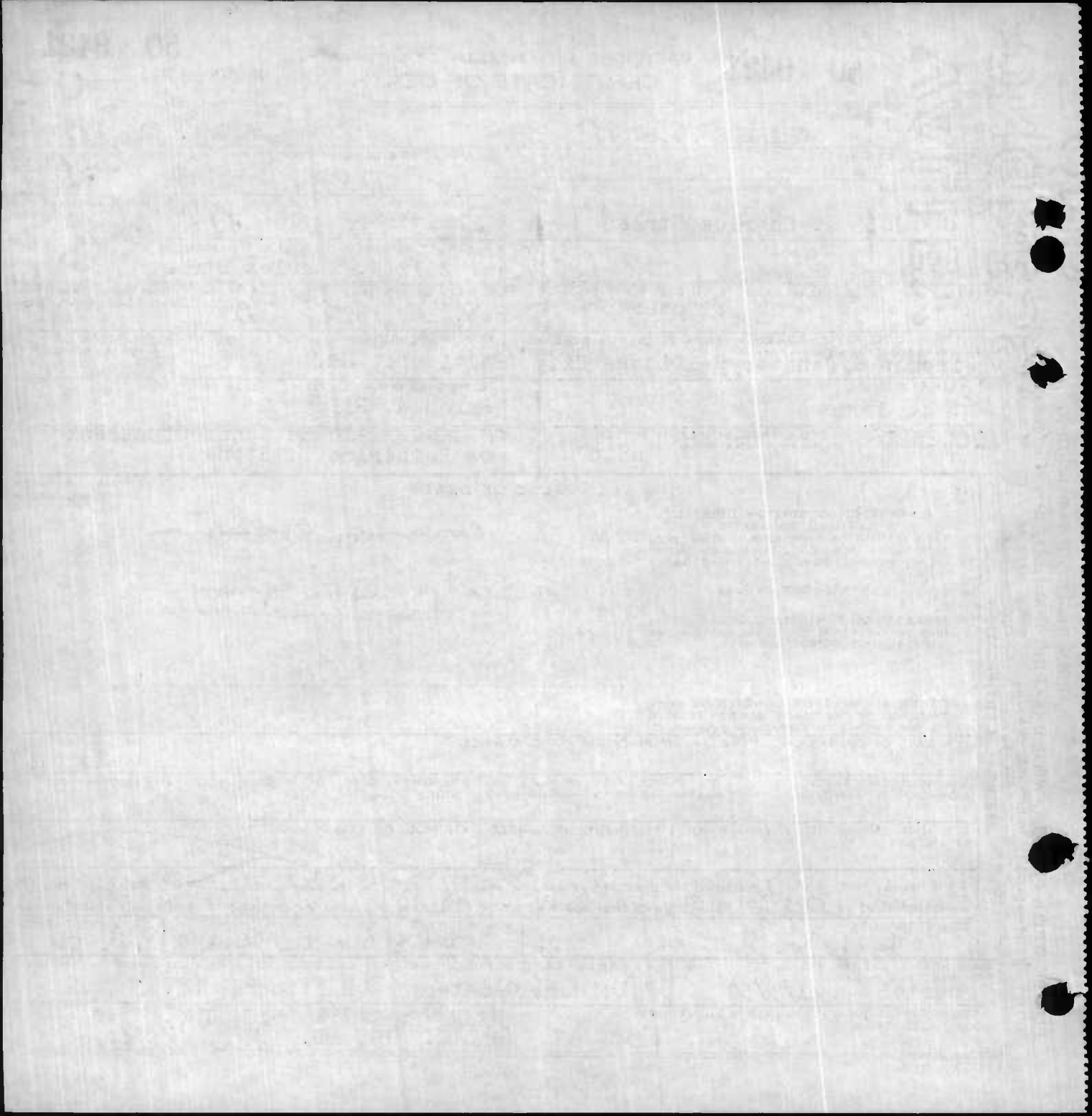
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 3-1950

770 93

937



B-525
REA-142890

50 9422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9422
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Carl Benson

2. DATE
OF
DEATH

Oct. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, state RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Earle Hotel

312 W Camden St

c. Length of stay in Baltimore

?

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
widower

8. DATE OF BIRTH

Jan 2, 1885

9. AGE (In years
last birthday)

65

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

BARTENDER

10B. KIND OF BUSINESS OR
INDUSTRY

HOTEL

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles A. Benson

14. MOTHER'S MAIDEN NAME

Tabitha Doudan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18.

490X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

24 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 10-27, 1950, to 10-28, 1950, that I last saw the
deceased alive on 10-28, 1950, and that death occurred at 5:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

11-2-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11/4/50

24C. NAME OF CEMETERY OR CREMATORY

Friends Burial Ground

24D. LOCATION (City, town, or county)

Harford County, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

HENRY SANDERSON & SONS, INC.

BALTO., 13, MD.

ADDRESS

*Specie & Co.*NOV 3-1950
VS 150

7508B

108

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



K-520
50 9423BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9423
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY V. KNAUS

2. DATE OF DEATH
NOVEMBER 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

00 4009 Glenmore Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-84

D. STREET ADDRESS (If rural, give location)

4009 Glenmore Ave.

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

8/28/65

9. AGE (In years last birthday)

85

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home Duties

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

John Jackson

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
None

17. INFORMANT

Mrs May Stafford

ADDRESS

18. 490X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

LOBAR PNEUMONIA

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

8 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MYOCARDIAL DEGENERATION

2 YRS +

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/24, 1948 to 11/2, 1950, that I last saw the deceased alive on 11/1, 1950, and that death occurred at 3 A. M., from the causes and on the date stated above.

23A. SIGNATURE

R. W. Machen

M. D.

23B. ADDRESS

6331 BELAIR RD - 6

23C. DATE SIGNED

11-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Nov. 4, 1950

24C. NAME OF CEMETERY OR CREMATORY

Landon Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1913 W. Cole Balto, Md.

NOV 3 1950

108

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8510 02

8510 02

11

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HAMBURGER, JOHN

2. DATE
OF
DEATH

11/3/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

BALTIMORE

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

UNIVERSITY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

HALETHORPE

5200

D. STREET ADDRESS (If rural, give location)

5616 SELMA AVE.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

33

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

INSURANCE AGENT

10B. KIND OF BUSINESS OR
INDUSTRY

INSURANCE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

OSCAR HAMBURGER

14. MOTHER'S MAIDEN NAME

CORA LYNN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
214-03-1280

17. INFORMANT

ADDRESS

18. 42011

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) CORONARY THROMBOSIS

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

12 DAY

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6:30 11/2, 1950, to 6:40 11/2, 1950, that I last saw the
deceased alive on 6:30 11/2, 1950, and that death occurred at 6:40 m., from the causes and on the date stated above.

23A. SIGNATURE

Donald Bach

M. D.

23B. ADDRESS

UNIVERSITY HOSPITAL

23C. DATE SIGNED

11/12

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/4/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral and Frederick Rd

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Christington Williams

25. FUNERAL DIRECTOR

Chas P. Towill

ADDRESS

NOV 3 - 1950

45073

94a

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1518 10

1518 10

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1518 10

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 9425
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Bramble

2. DATE
OF
DEATH

November 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Dorchester

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

U.S. Marine Hospital

Baltimore 11, Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Bishops Head

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 9, 1880

9. AGE (In years
last birthday)

70

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR
INDUSTRY

Seafaring

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Thomas Bramble

14. MOTHER'S MAIDEN NAME

Dora Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records - U.S. Marine Hospital, Balto., Md.

18. 421.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Calcific aortic valvulitis severe

XXXXX

ANTECEDENT CAUSES

(B) with stenosis, myocardial hypertrophy

unknown

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

XXXXX pulmonary edema

unknown

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from October 14, 1950, to Nov. 1, 1950, that I last saw the
deceased alive on Nov. 1, 1950, and that death occurred at 4:05 P.m., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Clinical Director M.D.

23B. ADDRESS

U.S. Marine Hospital, Balto., Md. 11-2-50

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

25A. FUNERAL HOME

25B. ADDRESS

25C. CITY

25D. STATE

25E. PHONE NO.

25F. SIGNATURE

25G. ADDRESS

25H. CITY

25I. STATE

25J. PHONE NO.

25K. SIGNATURE

25L. ADDRESS

25M. CITY

25N. STATE

25O. PHONE NO.

25P. SIGNATURE

25Q. ADDRESS

25R. CITY

25S. STATE

25T. PHONE NO.

25U. SIGNATURE

25V. ADDRESS

25W. CITY

25X. STATE

25Y. PHONE NO.

25Z. SIGNATURE

25AA. ADDRESS

25AB. CITY

25AC. STATE

25AD. PHONE NO.

25AE. SIGNATURE

25AF. ADDRESS

25AG. CITY

25AH. STATE

25AI. PHONE NO.

25AJ. SIGNATURE

25AK. ADDRESS

25AL. CITY

25AM. STATE

25AN. PHONE NO.

25AO. SIGNATURE

25AP. ADDRESS

25AQ. CITY

25AR. STATE

25AS. PHONE NO.

25AT. SIGNATURE

25AU. ADDRESS

25AV. CITY

25AW. STATE

25AX. PHONE NO.

25AY. SIGNATURE

25AZ. ADDRESS

25BA. CITY

25BB. STATE

25BC. PHONE NO.

25BD. SIGNATURE

25BE. ADDRESS

25BF. CITY

25BG. STATE

25BH. PHONE NO.

25BI. SIGNATURE

25BJ. ADDRESS

25BK. CITY

25BL. STATE

25BM. PHONE NO.

25BN. SIGNATURE

25BO. ADDRESS

25BP. CITY

25BQ. STATE

25BR. PHONE NO.

25BS. SIGNATURE

25BT. ADDRESS

25BU. CITY

25BV. STATE

25BU. PHONE NO.

25BV. SIGNATURE

25BW. ADDRESS

25BX. CITY

25BX. STATE

25BX. PHONE NO.

25BY. SIGNATURE

25BY. ADDRESS

25BY. CITY

25BY. STATE

25BZ. PHONE NO.

25BZ. SIGNATURE

25BZ. ADDRESS

25BZ. CITY

25C0. STATE

25C0. PHONE NO.

25C0. SIGNATURE

25C0. ADDRESS

25C1. CITY

25C1. STATE

25C1. PHONE NO.

25C1. SIGNATURE

25C2. ADDRESS

25C2. CITY

25C2. STATE

25C2. PHONE NO.

25C3. SIGNATURE

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25C3. CITY

25C3. STATE

25C4. PHONE NO.

25C4. SIGNATURE

25C4. ADDRESS

25C4. CITY

25C5. STATE

25C5. PHONE NO.

25C5. SIGNATURE

25C5. ADDRESS

25C6. CITY

25C6. STATE

25C6. PHONE NO.

25C6. SIGNATURE

25C7. ADDRESS

25C7. CITY

25C7. STATE

25C7. PHONE NO.

25C8. SIGNATURE

25C8. ADDRESS

25C8. CITY

25C8. STATE

25C9. PHONE NO.

25C9. SIGNATURE

25C9. ADDRESS

25C9. CITY

25CA. STATE

25CA. PHONE NO.

25CA. SIGNATURE

25CA. ADDRESS

25CB. CITY

25CB. STATE

25CB. PHONE NO.

25CB. SIGNATURE

25CC. ADDRESS

25CC. CITY

25CC. STATE

25CC. PHONE NO.

25CD. SIGNATURE

25CD. ADDRESS

25CD. CITY

25CD. STATE

25CE. PHONE NO.

25CE. SIGNATURE

25CE. ADDRESS

25CE. CITY

25CF. STATE

25CF. PHONE NO.

25CF. SIGNATURE

25CF. ADDRESS

25CF. CITY

25CF. STATE

25CF. PHONE NO.

25CF. SIGNATURE

25CG. ADDRESS

25CG. CITY

25CG. STATE

25CG. PHONE NO.

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25CH. ADDRESS

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25CH. ADDRESS

25CH. CITY

25CH. STATE

25CH. PHONE NO.

25CH. SIGNATURE

25CH. ADDRESS

25CH. CITY

25CH. STATE

25CH. PHONE

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
Last Name, First Name, Middle Initial		Month, Day, Year		Male Female	
Place of Birth		Date of Death		Time of Death	
City, State, Country		Month, Day, Year		Hour, Minute	
Cause of Death		Manner of Death		Place of Death	
Disease or Injury		Accident, Suicide, Homicide, Natural		Home, Hospital, Other	
Physician's Signature		Medical Examiner's Signature		Registrar's Signature	
Date of Signature		Date of Signature		Date of Signature	
Month, Day, Year		Month, Day, Year		Month, Day, Year	
City, State, Country		City, State, Country		City, State, Country	
Hospital, Clinic, etc.		Hospital, Clinic, etc.		Hospital, Clinic, etc.	
Physician's Name		Medical Examiner's Name		Registrar's Name	
Physician's Title		Medical Examiner's Title		Registrar's Title	
Physician's Address		Medical Examiner's Address		Registrar's Address	
City, State, Country		City, State, Country		City, State, Country	
Physician's Phone		Medical Examiner's Phone		Registrar's Phone	
City, State, Country		City, State, Country		City, State, Country	
Physician's Fax		Medical Examiner's Fax		Registrar's Fax	
City, State, Country		City, State, Country		City, State, Country	
Physician's Email		Medical Examiner's Email		Registrar's Email	
City, State, Country		City, State, Country		City, State, Country	
Physician's Website		Medical Examiner's Website		Registrar's Website	
City, State, Country		City, State, Country		City, State, Country	
Physician's Social Media		Medical Examiner's Social Media		Registrar's Social Media	
City, State, Country		City, State, Country		City, State, Country	
Physician's Other Contact		Medical Examiner's Other Contact		Registrar's Other Contact	
City, State, Country		City, State, Country		City, State, Country	
Physician's Notes		Medical Examiner's Notes		Registrar's Notes	
City, State, Country		City, State, Country		City, State, Country	
Physician's Signature		Medical Examiner's Signature		Registrar's Signature	
Date of Signature		Date of Signature		Date of Signature	
Month, Day, Year		Month, Day, Year		Month, Day, Year	
City, State, Country		City, State, Country		City, State, Country	
Hospital, Clinic, etc.		Hospital, Clinic, etc.		Hospital, Clinic, etc.	
Physician's Name		Medical Examiner's Name		Registrar's Name	
Physician's Title		Medical Examiner's Title		Registrar's Title	
Physician's Address		Medical Examiner's Address		Registrar's Address	
City, State, Country		City, State, Country		City, State, Country	
Physician's Phone		Medical Examiner's Phone		Registrar's Phone	
City, State, Country		City, State, Country		City, State, Country	
Physician's Fax		Medical Examiner's Fax		Registrar's Fax	
City, State, Country		City, State, Country		City, State, Country	
Physician's Email		Medical Examiner's Email		Registrar's Email	
City, State, Country		City, State, Country		City, State, Country	
Physician's Website		Medical Examiner's Website		Registrar's Website	
City, State, Country		City, State, Country		City, State, Country	
Physician's Social Media		Medical Examiner's Social Media		Registrar's Social Media	
City, State, Country		City, State, Country		City, State, Country	
Physician's Other Contact		Medical Examiner's Other Contact		Registrar's Other Contact	
City, State, Country		City, State, Country		City, State, Country	

K-625 50 9426		Krasnoff X 50 9426	
BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
BIRTH NO. <i>7.1.1</i>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Norman Eugene Krasnoff</i>		2. DATE OF DEATH <i>November 3, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>South Carolina</i> B. COUNTY <i>V-37</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Bishopville</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>August 11, 1950</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Sollie Krasnoff</i>		14. MOTHER'S MAIDEN NAME <i>Mildred Brill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Sollie L. Krasnoff- Bishopville, S. C.</i>	
18. <i>754.4</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Congenital heart diseases</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>2 mo. 23 days</i>			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Bronchopneumonia, bilateral</i>			
19A. DATE OF OPERATION <i>2</i>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>October 26, 1950</i> , to <i>November 3, 1950</i> , that I last saw the deceased alive on <i>Nov. 3, 1950</i> , and that death occurred at <i>6:00 A.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Robert D. Cox</i>		23B. ADDRESS <i>Union Memorial Hospital</i>	23C. DATE SIGNED <i>Nov. 3, 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	24B. DATE <i>11/3/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Hebrew Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Bishopville, S. C.</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>William M. Cox</i>	25. FUNERAL DIRECTOR <i>Sol. Levinson & Bros W. North</i>	

NOV 3 1950

157E Oneane



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9427**

630
50 9427
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jacob M. Hart				2. DATE OF DEATH 11-2-1950			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2716 Georgetown Road				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore 69 Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) 2716 Georgetown Road			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 20, 1878	9. AGE (In years last birthday) 72	If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leather Worker		10B. KIND OF BUSINESS OR INDUSTRY LEATHER GOODS		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jobe Hart				14. MOTHER'S MAIDEN NAME Louisa Earhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 212-07-9157		17. INFORMANT ADDRESS B. Mrs. Eva B. Hart 2716 Georgetown			
18. 163X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of the lung DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH approx 2 yrs			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/12 , 1950, to 11/2 , 1950, that I last saw the deceased alive on 11/1 , 1950, and that death occurred at 5:30 A m., from the causes and on the date stated above.							
23A. SIGNATURE Hubert A. Erickson				23B. ADDRESS 5305 East Drive		23C. DATE SIGNED 11/2/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-1950		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 3 - 1950		REGISTRAR'S SIGNATURE Walter J. Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.,			

VS 150

6904X

47D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr HJ Levickas
5305 EAST Drive

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9428

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) ALPHONSO-R-BURDETTE	2. DATE OF DEATH NOV-1-1950
---	------------------------------------

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Md	4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY _____
---	---

B. FULL NAME OF HOSPITAL OR INSTITUTION 3104 Cliftonmont Ave	C. CITY OR TOWN (If outside corporate limits, write FULL and give township) Balto
--	---

c. Length of stay in Baltimore Life	D. STREET ADDRESS (If rural, give location) 3104 Cliftonmont Ave
--	--

5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 22-1891	9. AGE (In years last birthday) 59	10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
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10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Styton	10B. KIND OF BUSINESS OR INDUSTRY Church	11. BIRTHPLACE (State or foreign country) Balto Md	12. CITIZEN OF WHAT COUNTRY? _____
--	--	--	---------------------------------------

13. FATHER'S NAME George Burdette	14. MOTHER'S MAIDEN NAME Emma Heider
---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____	16. SOCIAL SECURITY NO. 219-03-0744	17. INFORMANT ADDRESS Mrs Emma Burdette 3104 Cliftonmont
---	---	--

18. 442X	CAUSE OF DEATH
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DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) _____
DUE TO

**Hypertensive Cardio-Vascular
Renal Disease**

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO

Myocardial Failure

**year
3 days**

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------	----------------------------------	---

21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
---	---	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **1938** to **November**, 19**50** that I last saw the deceased alive on **11-31**, 19**50**, and that death occurred at **9:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE William R. Jeaniz	23B. ADDRESS 2025 Belair Road	23C. DATE SIGNED 11-1-50
--	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov 4-50	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	24D. LOCATION (City, town, or county) (State) Balto Md
--	------------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR NOV 3 1950	REGISTRAR'S SIGNATURE Wilmington Williams, M.D.	25. FUNERAL DIRECTOR Joe J. Har + Son	ADDRESS 770 SW 3001 Kentucky Ave
---	---	---	--

VS 150

121a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9429
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Tony C. Miller (Cocukis)

2. DATE
OF
DEATH

11/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Bon Secours Hosp.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

919 W. Lombard St.

C. Length of stay in Baltimore

? 39 yrs

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6/12/93

9. AGE (In years last birthday)

57

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Car Repairman

10B. KIND OF BUSINESS OR INDUSTRY

Ball Steel Stepping

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

PAULINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

21309-2288

17. INFORMANT

ADDRESS

Pauline Miller 919 W Lombard St.

18. *582X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Bacteremia, Friedlander's Bacillus*
DUE TO *Multiple liver abscesses*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

shock; Beriberi vascular shock

19A. DATE OF OPERATION

11/1/50

19B. MAJOR FINDINGS OF OPERATION

acute cholecystitis, multiple liver abscesses

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/25, 1950* to *11/2, 1950*, that I last saw the deceased alive on *11/2, 1950*, and that death occurred at *7:45* p.m., from the causes and on the date stated above.

23A. SIGNATURE

Frank G. Faronio

M. D.

23B. ADDRESS

Bon Secours Hospital

23C. DATE SIGNED

11/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov 6-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county) (State)

Beltin Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR

NOV 3 - 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Joseph Kaminicki Jr. 602 Wash.

ADDRESS

125B Blue

6903A

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9430

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BARRETT, Laura

2. DATE
OF
DEATH

11-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

UNIVERSITY Hosp

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

UNIVERSITY Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2007 BELAIR Rd #13

c. Length of stay in Baltimore

LIFE

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE ☒ MARRIED ☒
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1901-Jan-25

9. AGE (In years
last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

HOUSEWIFE

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JACOB DIETER

14. MOTHER'S MAIDEN NAME

MARGARET MANNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-07-1697

17. INFORMANT

ADDRESS

18. 193X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

DUE TO

Post-operative coma following 14 days
CLANOTOMY

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

CEREBRAL SPINAL FLUID BLOCKAGE

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10-18-50

19B. MAJOR FINDINGS OF OPERATION

Tumor in region of upper aqueduct (over)

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-31, 1950, to 11-2, 1950, that I last saw the
deceased alive on 11-1, 1950, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

A. J. Boyles

23B. ADDRESS

University Hosp

23C. DATE SIGNED

11-2-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

11/6/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

M. J. Williams

25. FUNERAL DIRECTOR

J. H. Herr + Son

ADDRESS

3001 Kentucky Ave
5420

When autopsy findings become
available, may we be advised

if this was a malignant tumor of the brain?

If so, was this the primary site?

If secondary, please specify the presumable primary
site,
if known.

See Autopsy findings Document File 50-9430

1/8/1951

ESTeman

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9431

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Charlotte Florence Leimkuhler

2. DATE

OF

DEATH Nov. 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION00 706 Northern Parkway

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

706 Northern Parkway

5. SEX

Female

6. COLOR OR RACE

White7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)Single

8. DATE OF BIRTH

May 8, 19149. AGE (In years
last birthday)36If Under 1 Year
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William J. Leimkuhler

14. MOTHER'S MAIDEN NAME

Olive M. Smith15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

William J. Leimkuhler706 Northern
Parkway

18.

581.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Curbing of liverINTERVAL BETWEEN
ONSET AND DEATH24

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 23, 1946 to Nov 2, 1950, that I last saw the
deceased alive on Nov 1, 1950, and that death occurred at 2 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Frederick J. Vallentyne

M. D.

23B. ADDRESS

6100 York Road

23C. DATE SIGNED

Nov 2, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)Burial

24B. DATE

11/4/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Frederick J. Vallentyne

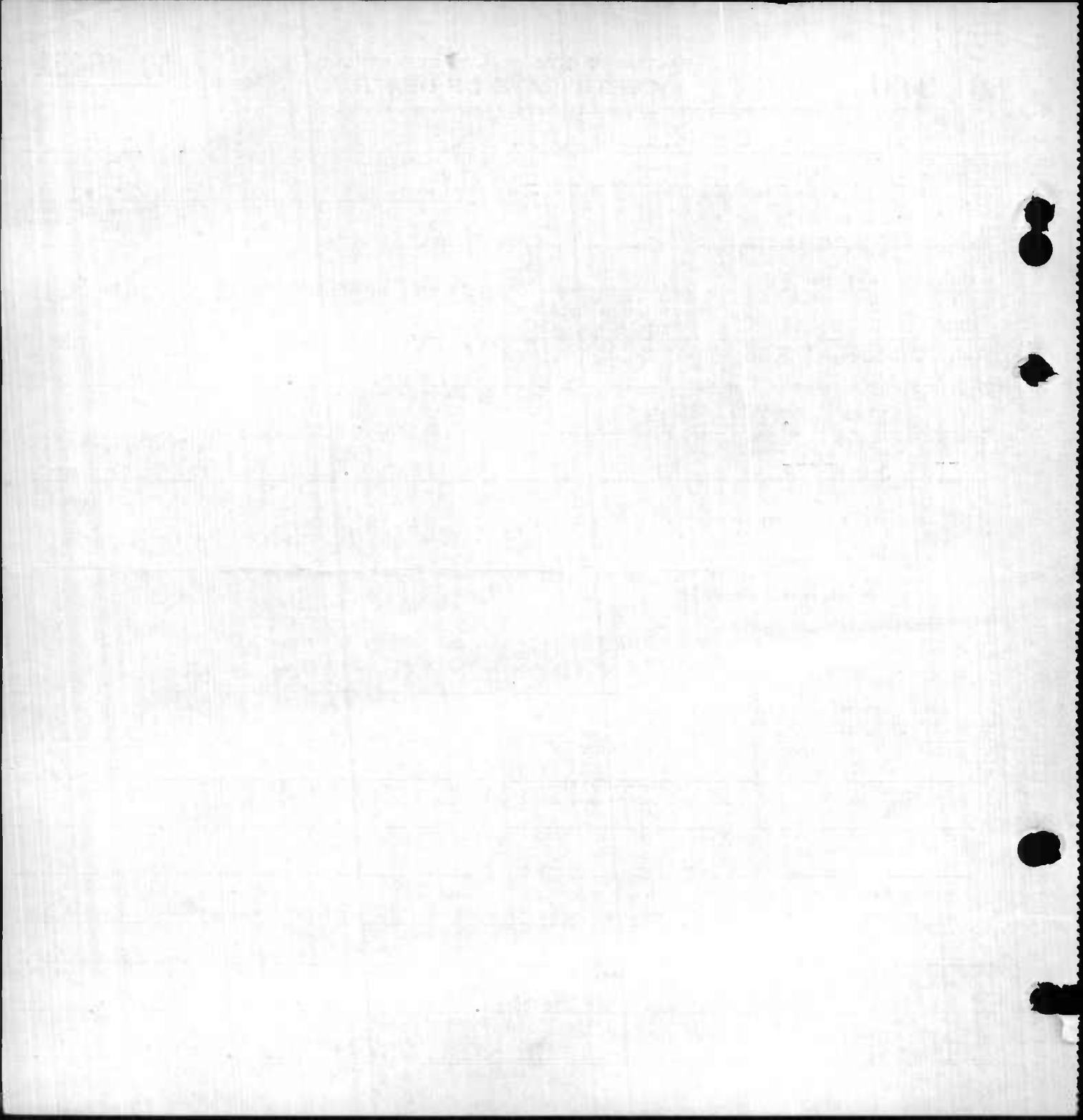
25. FUNERAL DIRECTOR

ADDRESS

John A. Moran3000 E. Baltimore St.

VS 150

124B



W#300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9432

Registered No.

50 9432

1. NAME OF DECEASED (Type or Print) <i>Alice M. White</i>			2. DATE OF DEATH <i>Nov-2-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>4212 Parkmont Ave</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>8-03</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>60 Hamilton Armspurg House</i>			C. CITY OR TOWN (If outside corporate limits, give R.U.P.A.L. and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>2614 E. Hoffman St</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>July-15-1884</i>		9. AGE (In years last birthday) Months: Days <i>66</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Phila Pa</i>	
13. FATHER'S NAME <i>Franklin Hollowell</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Sullivan</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Andrew C. White - Right Wing Drive - Balto. Sp. Md</i>	
18. <i>174X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Terminal Broncho pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> (A) DUE TO ANTECEDENT CAUSES (B) <i>Carcinoma of uterus</i> DUE TO <i>about 3 yrs</i> (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>10/2/50</i>		19B. MAJOR FINDINGS OF OPERATION <i>Inoperable Carcinoma of uterus</i>			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/7/50</i> , 19__, to <i>11/4/50</i> , 19__, that I last saw the deceased alive on <i>11/4/50</i> , 19__ and that death occurred at <i>4:45 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Max Baum</i>		23B. ADDRESS M. D. <i>1501 N. Milton Ave</i>		23C. DATE SIGNED <i>11/3/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <i>11-6-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Belair Rd - Balto. Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 3 - 1950</i>		REGISTRAR'S SIGNATURE <i>Christington Williams, Md</i>		25. FUNERAL DIRECTOR ADDRESS <i>John C. Mully Inc - 2435 E. Oliver St</i>	

VS 150

48 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

— 20 —

1997

2. 4. 2004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9433

1. NAME OF DECEASED (Type or Print) SARAH KATHARINE BUTLER			2. DATE OF DEATH November 2, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION Union Memoiral Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Riderwood		
c. Length of stay in Baltimore 29 years			D. STREET ADDRESS (If rural, give location) Sherwood Road		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 10, 1921	9. AGE (in years last birthday) 29	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Maurice Butler			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			14. MOTHER'S MAIDEN NAME Edith Reese		
16. SOCIAL SECURITY NO.			17. INFORMANT Maurice Butler		
			ADDRESS Riderwood, Md.		

18. E976x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) INTERNAL HYDROCEPHALUS bullet wound of the head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) Internal hydrocephalus bullet wound of the head (B) (C)	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sherwood Road, Riderwood, Maryland
21D. TIME (Month) (Day) (Year) (Hour) August 20, 1950 12:30 A.	21E. INJURY OCCURRED OF INJURY WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Firearms
22. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE Stanley H. Orulacher M.D.	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER.....	23C. DATE SIGNED 11-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-4-1950	24C. NAME OF CEMETERY OR CREMATORY Druid Ridge	24D. LOCATION (City, town, or county) (State) Pikesville Md.
DATE RECEIVED BY LOCAL REGISTRAR NOV 3-1950	REGISTRAR'S SIGNATURE Wilmington Williams, M.D.	25. FUNERAL DIRECTOR John O. Mitchell Sons	ADDRESS 1900 Eutaw Place

VS 151

N 850.2

164c ✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11. *Journal of the American Medical Association*, 277, 1996, 1031-1034.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9434

Registered No. _____

BIRTH NO.

5-320
50 9434

1. NAME OF DECEASED (Type or Print) <i>anne Shattuck</i>		2. DATE OF DEATH <i>November 1, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i> <i>33</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>14-01</i>	
c. Length of stay in Baltimore <i>27</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1407 Eutan Place</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12-15-70</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>79</i> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <i>Lowell, Mass.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Moses Gibson</i>		14. MOTHER'S MAIDEN NAME <i>Ninbale Gage</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>550.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Generalized peritonitis</i> DUE TO		CAUSE OF DEATH <i>Generalized peritonitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Perforated appendix</i> DUE TO		(B) <i>Perforated appendix</i> DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Emphysema</i>		(C) <i>Emphysema</i>		
19A. DATE OF OPERATION <i>10-28-50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Peritonitis - acute perforated appendix</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>10-28</i> , 19 <i>50</i> , to <i>11-1</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11-1</i> , 19 <i>50</i> , and that death occurred at <i>10:00 P.M.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>David C. Harrison</i> M. D.		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>1/1/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>	24B. DATE <i>11-4-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>	24D. LOCATION (City, town, or county) (State) <i>Greenmount Ave. Balto. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 3 - 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. Williams</i>		25. FUNERAL DIRECTOR <i>John D. Mitchell</i> ADDRESS <i>Emosine 1900 Eutan St</i>

100 00 100 00

100 00 100 00

100 00 100 00

100 00 100 00

100 00 100 00

100 00 100 00

100 00 100 00

100 00 100 00

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Fred Fielding

2. DATE
OF
DEATH

November 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

New York

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

U.S. Marine Hospital

Baltimore 11, Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

New York

D. STREET ADDRESS (If rural, give location)

101 W. 58th Street

c. Length of stay in Baltimore

unk.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 5, 1895

9. AGE (In years
last birthday)

55

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Steward

10B. KIND OF BUSINESS OR
INDUSTRY

Seafaring

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

086-16-9222

17. INFORMANT

ADDRESS

Records - US Marine Hospital, Balto., Md.

18. 540.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Peritonitis, acute, generalized

48 to

DUE TO

ANTECEDENT CAUSES

(B) perforated peptic ulcer.

72 hours

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from November 2, 1950, to November 2, 1950, that I last saw the
deceased alive on Nov. 2, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

23B. ADDRESS

US Marine Hospital, Balto., Md.

23C. DATE SIGNED

11-3-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

removal

24B. DATE

11/3/50

24C. NAME OF CEMETERY OR CREMATORY

Jamaica

24D. LOCATION (City, town, or county)

Long Island, New York

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc.

1217 St. Paul Street

NOV 3 1950

764 55

117a

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Informant		12. Date of Entry	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-560

50 9436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9436

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) POSEY SUMNER			2. DATE OF DEATH NOV 3, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland HAL 1			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE VIRGINIA B. COUNTY V-43		
5. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ROANOKE		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 917 W. CAMPBELL AVE.		
6. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 5-17-00	9. AGE (In years last birthday) 50	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER			11. BIRTHPLACE (State or foreign country) VIRGINIA		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME DAVID SUMNER			14. MOTHER'S MAIDEN NAME MIRANDA CONNER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT JOHNS HOPKINS HOSPITAL			ADDRESS		

18. 143X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Cause of Death (B) Carcinoma - floor of mouth DUE TO	INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

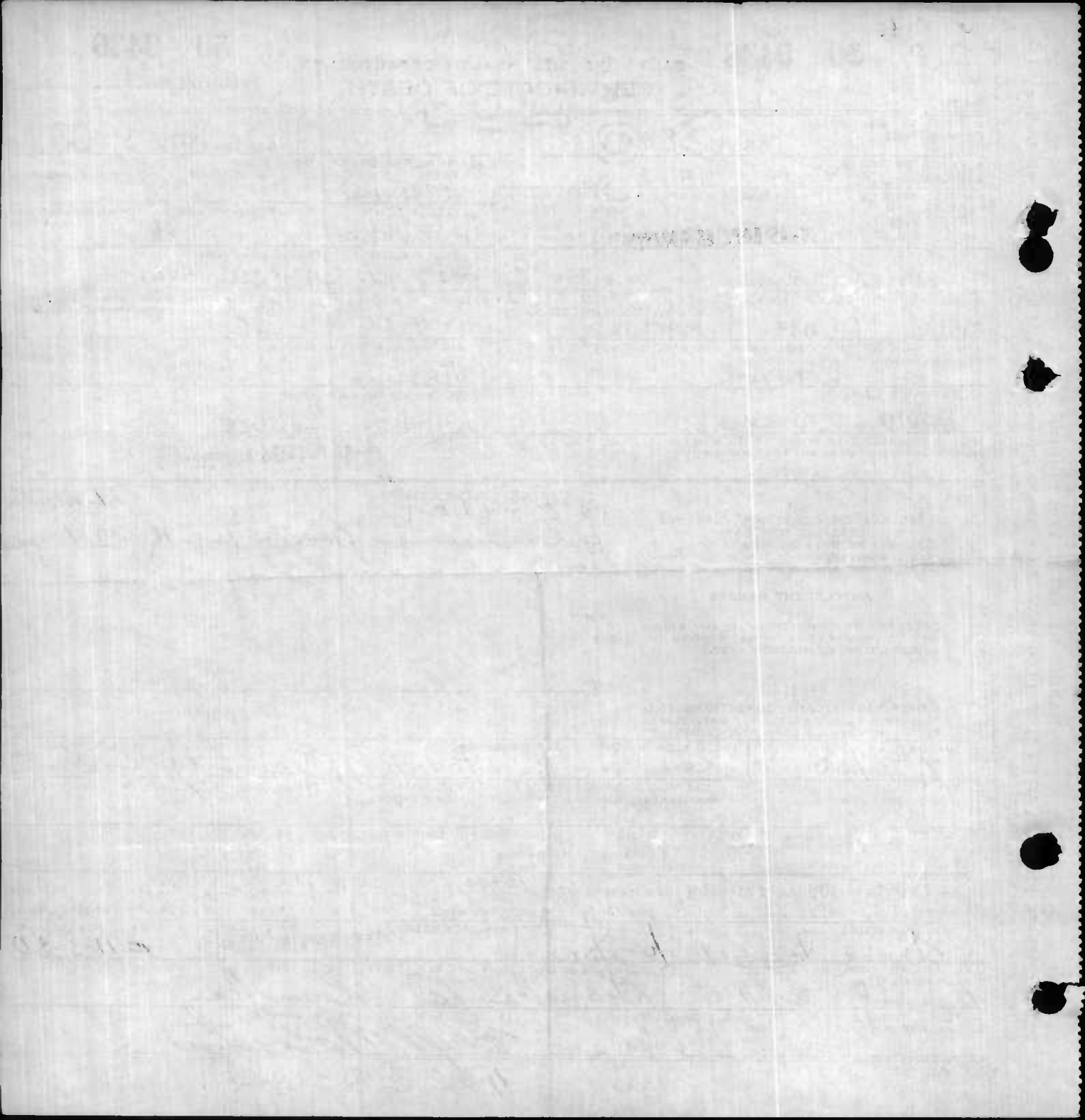
19A. DATE OF OPERATION 7/20/50	19B. MAJOR FINDINGS OF OPERATION Carcinoma of Palate (Recurrent)	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 10-11 , 19 50 , to 11-3 , 19 50 , that I last saw the deceased alive on 11-3 , 19 50 , and that death occurred at 5:15 a.m., from the causes and on the date stated above.		
23A. SIGNATURE David C. Salistey	23B. ADDRESS JOHNS HOPKINS HOSPITAL	23C. DATE SIGNED 11-3-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 11-3-50	24C. NAME OF CEMETERY OR CREMATORY Roanoke VA
24D. LOCATION (City, town, or county) (State) Roanoke	25. FUNERAL DIRECTOR Earl B. Volante	ADDRESS

NOV 3-1950

0558U

403 @ 25th St.

45c



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9437

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HARRY

JOHNSON

2. DATE
OF
DEATH

Nov. 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

839 N. Eutaw St.

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED DIVORCED (Specify)

8. DATE OF BIRTH

May 11 1885

9. AGE (In years last birthday)

45

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

CONST.

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Johnson

14. MOTHER'S MAIDEN NAME

Emily Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Nephietta Keeney

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Stanley D. Decker

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Nov. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

11-4-50

24C. NAME OF CEMETERY OR CREMATORY

Family Plot

24D. LOCATION (City, town, or county)

Somersville, N.Y.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

W W Chambers Co

8000 00

STATEMENT OF HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8000 00

1

20

STATE OF DEATH

DEPARTMENT OF HEALTH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

DEPARTMENT OF HEALTH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

DEPARTMENT OF HEALTH

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DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9438
Registered No. _____

1200
50 9438
BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) William E. Tesso			2. DATE OF DEATH Nov 3 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 1017 E. Pratt St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION _____			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 1017 E. Pratt St.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 23 1915		9. AGE (In years last birthday) 34
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owners			11. BIRTHPLACE (State or foreign country) Bluefield W.Va.		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME Charles Tesso			14. MOTHER'S MAIDEN NAME Rosemaria French		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Pauline Tesso (Wife) 1017 E. Pratt St.		

18. 193X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RETROPERITONEAL NEUROGENIC SARCOMA Carcinoma of Stomach. DUE TO with metastasis to LIVER		INTERVAL BETWEEN ONSET AND DEATH 5 mo. 2 mo.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an _____ thereon and from _____ the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE R S Fisher		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED 11/3/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE Nov. 4th 1950		24C. NAME OF CEMETERY OR CREMATORY Bluefield W.Va.	

DATE RECEIVED BY LOCAL REGISTRAR NOV 4 - 1950		REGISTRAR'S SIGNATURE Frank Della Lora		25. FUNERAL DIRECTOR ADDRESS 322 S. High St.	
---	--	--	--	--	--

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

See Document File 50-9438

For Corrected Data

11-15-50

ES.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Singdahlsen

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 9439

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Charlotte Singdahlsen

2. DATE
OF
DEATH November 1, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY _____

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

2811 Glendale Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2811 Glendale Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 14, 1873

9. AGE (In years,
last birthday)

77

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Larvik, Norway

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wils Steen

14. MOTHER'S MAIDEN NAME

Julia Tingberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Sylvia S. Boileau, 2811 Glendale Ave.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic
Cardiovascular Disease

5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

no

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 2, 1950, to 1 Nov, 1950, that I last saw the deceased alive on 30 Oct, 1950, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Edward L. Hughes, M.D.

23B. ADDRESS

7425 Harford Rd.

23C. DATE SIGNED

3 Nov 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11/4/50

24C. NAME OF CEMETERY OR CREMATORY

Crestland Park

24D. LOCATION (City, town, or county)

Parkville,

(State)

Maryland

DATE RECEIVED BY

LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

H. M. Cook, Inc.

ADDRESS

1217 St. Paul Street

0214 02

0214 02

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9440
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Julia Daidone or Di Peppe			2. DATE OF DEATH Nov. 2nd 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 2801 E. Biddle St.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION _____			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 35yrs			D. STREET ADDRESS (If rural, give location) 2801 E. Biddle St.		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 13 1887		9. AGE (in years, last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Eucchanico Italy		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME Camillo Cucchia			14. MOTHER'S MAIDEN NAME Margherita Masciulla		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS Elizabeth Di Peppe 2801 E. Biddle St.	

<p>18. 171X</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) Carcinoma of Cervix (Primary) DUE TO</p> <p>(B) metastasis to Liver. DUE TO</p> <p>(C) _____</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>
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19A. DATE OF OPERATION May 1950		19B. MAJOR FINDINGS OF OPERATION carcinoma cervix		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 10/9 1950 , to 11/7 1950 , that I last saw the deceased alive on 11/1 1950 , and that death occurred at 11/3 1950 , from the causes and on the date stated above.					
23A. SIGNATURE A. S. Hornstein		23B. ADDRESS 204 E. Biddle St		23C. DATE SIGNED 11/3/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 4th	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Balt. Md.		
DATE RECEIVED BY LOCAL REGISTRAR NOV 4 - 1950		25. FUNERAL DIRECTOR ADDRESS Frank Della Rocca 322 S. High St.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1991 1992 1993

132 • *Journal of Interpersonal Violence* 23(1)

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2510

9

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9441
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Marie L. Morrow

2. DATE
OF
DEATH

Nov. 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3604 Mohawk Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Anderson Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

3 E. Read St.

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Aug. 24, 1884

9. AGE (in years
last birthday)

66

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

School teacher

10B. KIND OF BUSINESS OR
INDUSTRY

Public Schools

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James S. Morrow

14. MOTHER'S MAIDEN NAME

Lydia Ann Fogelman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

James S. Morrow 3746 Tudor Arms Ave.

18. 350X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pneumonia

DUE TO

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Parkinson's syndrome

DUE TO

8 years

(C) Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 August, 1949, to 3 Nov., 1950, that I last saw the
deceased alive on 2 Nov., 1950, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Douglas Lockard

M. D.

23B. ADDRESS

802 Cathedral St.

23C. DATE SIGNED

4 Nov., 1950.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/6/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 4 - 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell & Sons 1900 Eutaw Place

Re. J. D. Lockard

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9442
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELLA HARDY

2. DATE
OF
DEATH

Nov 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Osh. 4 Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

C. Length of stay in Baltimore

20 Yrs.

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

609 ASQUITH ST.

5. SEX

FEMALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

10-11-39

9. AGE (In years
last birthday)

39

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY HARDY

14. MOTHER'S MAIDEN NAME

JENNY Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

444 X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

10 years

3 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-22 1950, to 11-1 1950, that I last saw the
deceased alive on 11-1 1950, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

J. J. Langford

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/4/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 4 - 1950

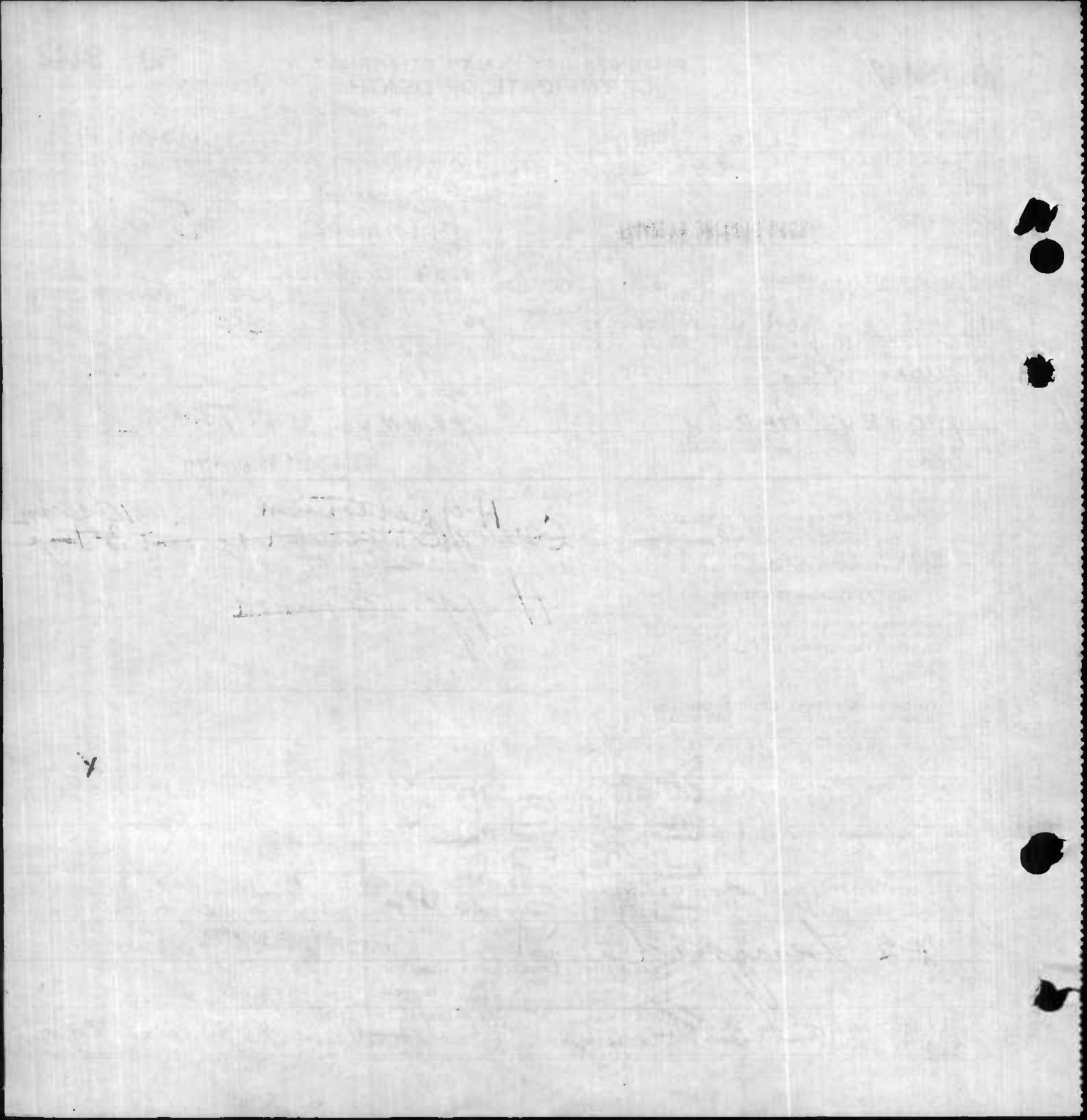
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Chry's Wilson 1000 Brantly ave

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9443**

H-200
50 9443 50-06140

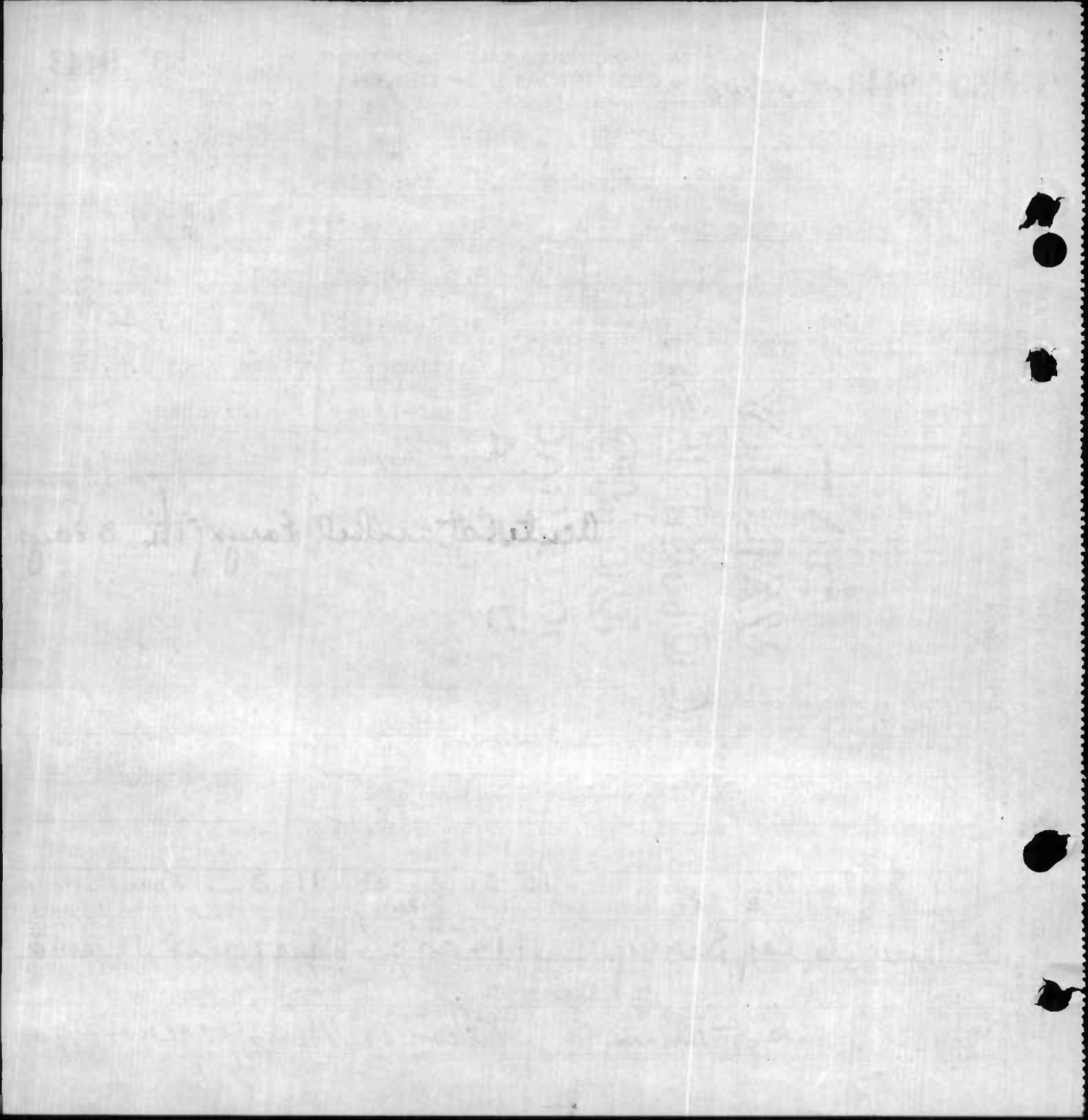
1. NAME OF DECEASED (Type or Print) Wayne Benett Hayes			2. DATE OF DEATH Nov. 3, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City B. FULL NAME OF HOSPITAL OR INSTITUTION 926 Harlem Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City D. STREET ADDRESS (If rural, give location) 926 Harlem Avenue		
c. Length of stay in Baltimore Life			Yrs. Mos. Days		
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March. 22, 1950		9. AGE (in years, last birthday) 7 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jesse Hayes		
14. MOTHER'S MAIDEN NAME Isabel Bratcher			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Jesse Hayes 926 Harlem Avenue		

18. 474X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Catarrhal Laryngitis	CAUSE OF DEATH Acute Catarrhal Laryngitis	INTERVAL BETWEEN ONSET AND DEATH 3 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10. 31 , 19 50 to 11. 3 , 19 50 that I last saw the deceased alive on 11. 3 , 19 50 and that death occurred at 2:20 a.m. , from the causes and on the date stated above.					
23A. SIGNATURE Wm. L. Royberry		23B. ADDRESS 1420 E. Chase Street		23C. DATE SIGNED 11. 3. 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 4, 1950		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Brooklyn Maryland		24E. FUNERAL DIRECTOR Clayton O. Wilson		24F. ADDRESS 1000 Brantly an	
DATE RECEIVED BY LOCAL REGISTRAR NOV 4 - 1950		REGISTRAR'S SIGNATURE Thurston Williams, M.D.		24G. ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

532
50 9444

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 9444

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
SAMUEL EDWIN LINTHICUM		Nov. 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2909 Erdman Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-01	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 2909 Erdman Avenue	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 17, 1885
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-ret.		10B. KIND OF BUSINESS OR INDUSTRY ship building	9. AGE (In years, last birthday) 65
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel W. Linthicum		14. MOTHER'S MAIDEN NAME Margaret Ann Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 141-07-4186	
17. INFORMANT Mrs. Ann E. Linthicum		18. ADDRESS 2909 Erdman Avenue - 13	

18. 422.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Congestive Heart Failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO Arteriosclerotic Cardio Vascular disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) ... Cerebral Degeneration			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan, 1948, to Nov. 1, 1950, that I last saw the deceased alive on Nov. 1, 1950, and that death occurred at 4:10 P. M., from the causes and on the date stated above.					
23A. SIGNATURE L. B. Stevens		23B. ADDRESS 3400 Erdman Ave		23C. DATE SIGNED Nov. 3, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 11/4/50		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery Baltimore, Md.	
24D. LOCATION (City, town, or county) BALTO., 13, MD.		25. FUNERAL DIRECTOR HENRY SANDER & SONS INC.		ADDRESS Deleese J. Hill	
DATE RECEIVED BY NOV 4 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.			

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9445**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT LAURENCE HARRIS

2. DATE
OF
DEATH

Nov. 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

316 Broadmoor Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

316 Broadmoor Rd.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
widowed

8. DATE OF BIRTH

July 24, 1884

9. AGE (In years
last birthday)

66

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Architect

10B. KIND OF BUSINESS OR
INDUSTRY

CONSULT.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John L. Harris, Sr.

14. MOTHER'S MAIDEN NAME

Mary Jane Calder

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Edward Funk, Jr. 316 Broadmoor Rd.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arterio sclerosis & Hypertension
DUE TO C Myocardial failure

8+ years

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Intestinal Hemorrhage

24 hours

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1943, 19 to 11/2/50, 19, that I last saw the
deceased alive on 11/2/50, 19, and that death occurred at 2 P m., from the causes and on the date stated above.

23A. SIGNATURE

Francis W. Glueck

M. D.

23B. ADDRESS

3406 St Paul St

23C. DATE SIGNED

11/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/4/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

NOV 4 - 1950

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

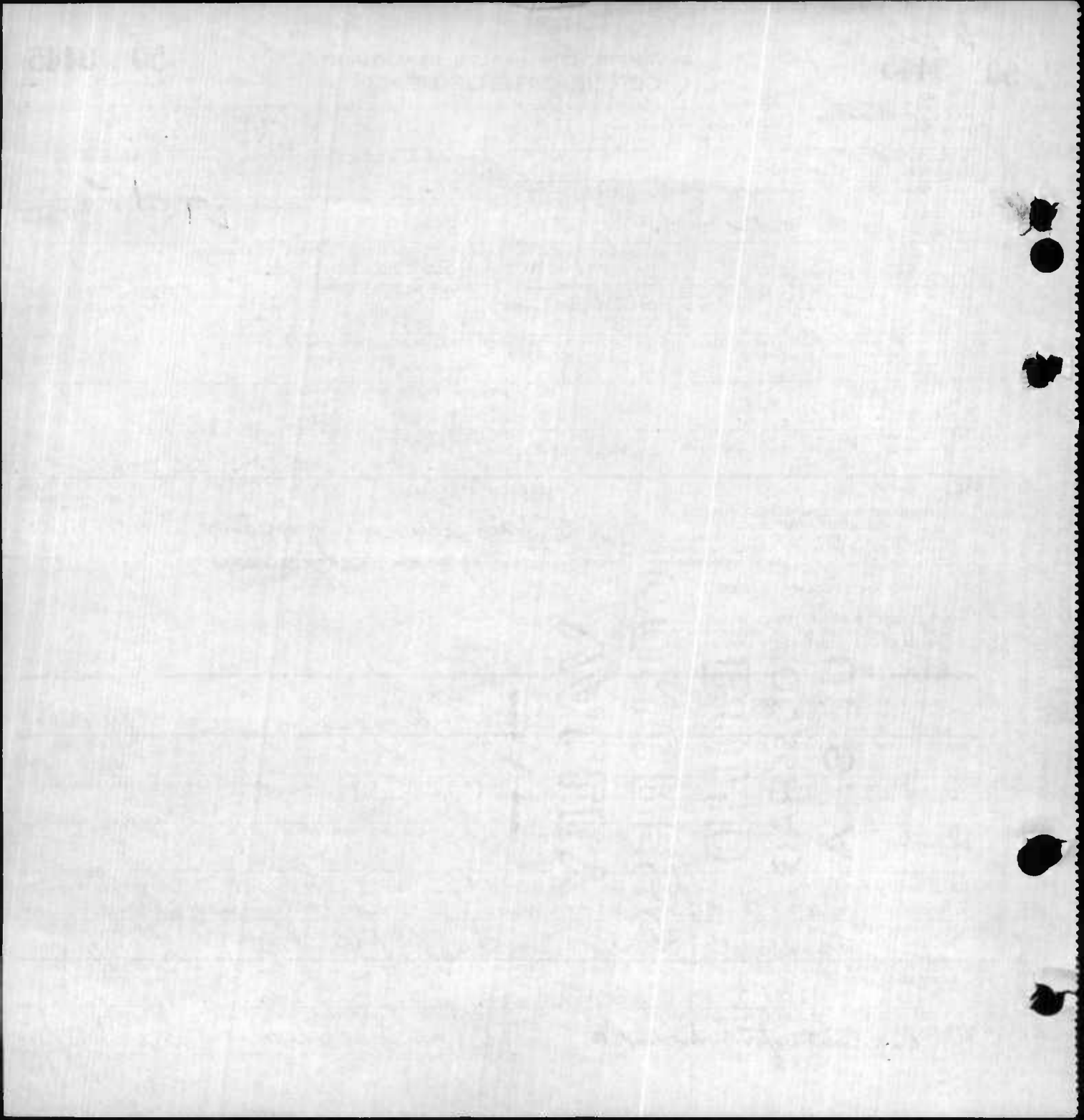
ADDRESS

Wm. J. Dickner & Sons Balto

VS 150

00324

97 Md.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9446

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE DATCH

2. DATE
OF DEATH November 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

4918 Poe Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4918 Poe Avenue

c. Length of stay in Baltimore

26 yrs.

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1890

9. AGE (In years last birthday)

60

If Under 1 Year

Months

If Under 24 Hours

Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Joseph Pinchesky

14. MOTHER'S MAIDEN NAME

Sarah ??

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Max Datch- 4918 Poe Avenue

ADDRESS

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardio

DUE TO

Renal Vascular Disease

10 years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from Jan, 1950, to 11/3, 1950, that I last saw the deceased alive on 11/3, 1950, and that death occurred at 8:15 a. m., from the causes and on the date stated above.

23A. SIGNATURE

J. J. Zimberly

M. D.

23B. ADDRESS

2300 Zupark Rd

23C. DATE SIGNED

11/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/5/50

24C. NAME OF CEMETERY OR CREMATORY

Shaarei Tfiloh Cong.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 4 - 1950

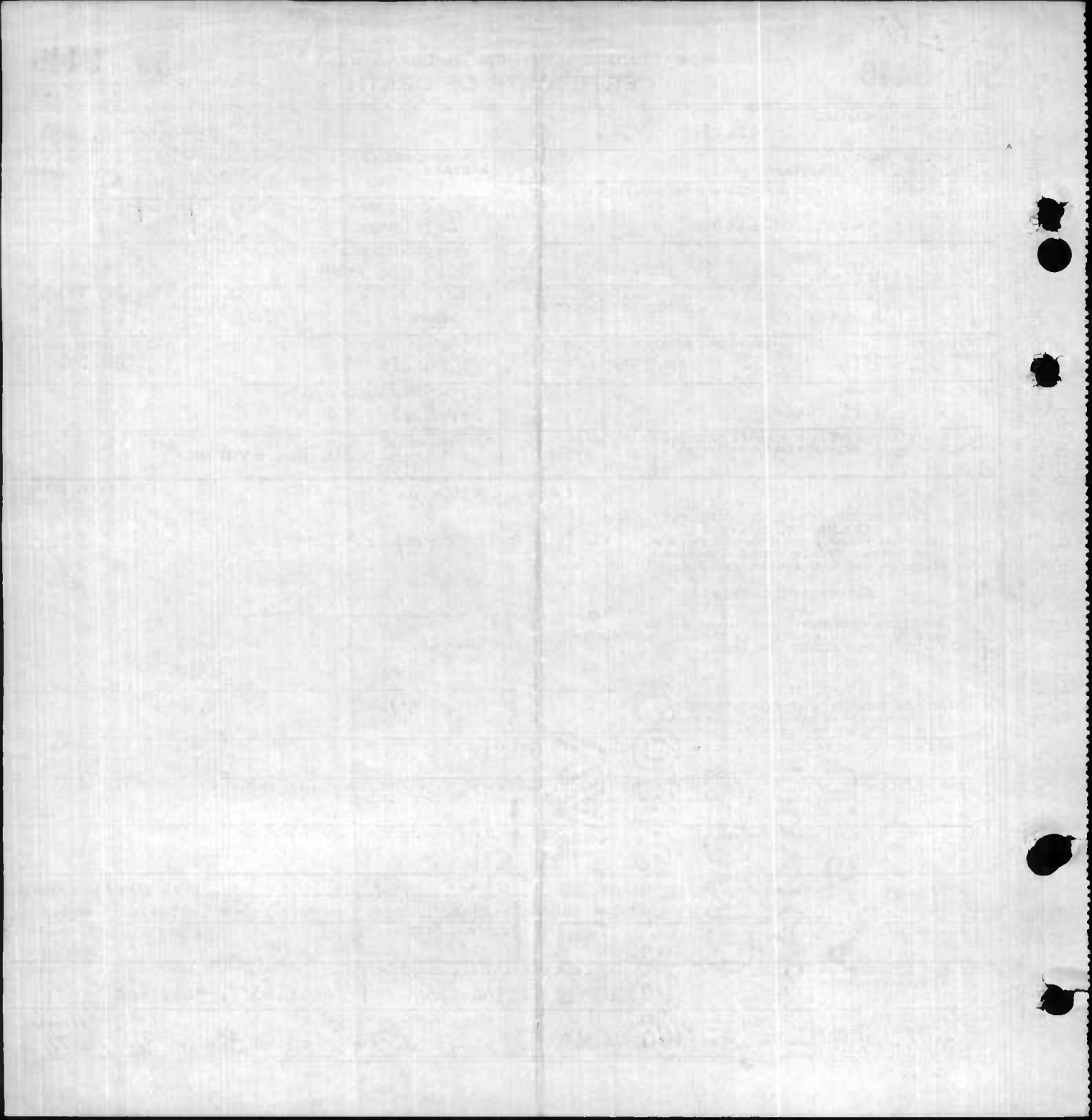
REGISTRAR'S SIGNATURE

J. J. Zimberly

25. FUNERAL DIRECTOR

Sol Levinson & Bros W Nathan

ADDRESS 1126



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH.

Registered No. 50 9447

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) THOMAS BROWDER

2. DATE

OF DEATH October 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE Baltimore City Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

205 S. Collington Avenue

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years last birthday)

68

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

N

O

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. 490x

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Lobar pneumonia - lower left lobe

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIB-UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William J. Smith

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED

October 9, 1950

24A. BURIAL, CREMA-TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 31 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

V S 151

108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH
 CERTIFICATE OF DEATH

343

1960

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

OTHER CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF REGISTRAR

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF JUDGE

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF CLERK

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF NOTARY

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF JURY

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF COURT

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF JURY

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF COURT

DATE OF SIGNATURE

PLACE OF SIGNATURE

UNITED STATES DEPARTMENT OF HEALTH

WASHINGTON, D.C.

CERTIFICATE CORRECTED 11-9-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 9448

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES

BRAXTON

2. DATE
OF
DEATH

October 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

St. Joseph's Hospital

Yrs.
Mos.
Days

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U N

9. AGE (In years
last birthday)

42

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

N

17. INFORMANT

N

ADDRESS

✓

18. 023X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Luetic aortitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Decker

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....23C. DATE SIGNED
10-27-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 31 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 4 - 1950

VS 151

Commander of Health

309 ✓

8413

RECORDS OF THE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

8413

30



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 9449**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Herman FOWLER

2. DATE
OF
DEATH

Oct. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Washington, D.C.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

623 Pennsylvania Ave.

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years last birthday)

48

10 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. **E 929.8**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Drowning**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Acute alcoholism**

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
harbor

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Pier #4 Pratt St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
Oct. 16, 1950 abt. 3 pm.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell into harbor while in intoxicated condition

22. I certify that I took charge of the remains described above, held an **Autopsy** **condition** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Durlacher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Oct. 18, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Franklin H. Williams, M.D.

UNIVERSITY MEDICAL SCHOOL OCT 31 1950
Commissioner of Health

ADDRESS

VS 151

N 990 X

183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9450**BIRTH NO. **50 9450**
50-24406

1. NAME OF DECEASED (Type or Print) Baby Boy Lewis			2. DATE OF DEATH Nov 2, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Lutheran Hosp of md			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 30		
c. Length of stay in Baltimore 29			D. STREET ADDRESS (If rural, give location) 1453 Light St		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Nov. 2, 1950	9. AGE (In years last birthday)	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Elmer Russell Lewis			14. MOTHER'S MAIDEN NAME Katherine Marie Griffin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS mother 1453 Light St		

MEDICAL CERTIFICATION	18. 776x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Atelectasis, bilateral DUE TO ANTECEDENT CAUSES Prematurity DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Atelectasis, bilateral Prematurity			INTERVAL BETWEEN ONSET AND DEATH 11 hrs 42 min.				
	19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
	22. I hereby certify that I attended the deceased from 4⁴³ am 11/2 1950 , to 3³⁰ pm 11/2 1950 , that I last saw the deceased alive on 11/2 1950 , and that death occurred at 3³⁸ m. , from the causes and on the date stated above.										
23A. SIGNATURE Samuel Silverstein M.D.			23B. ADDRESS Lutheran Hosp. of Md.			23C. DATE SIGNED 11/3/50					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE Nov. 4 - 50			24C. NAME OF CEMETERY OR CREMATORY Glent Haven Mem.			24D. LOCATION (City, town, or county) (State) Pitcher Highway Md.		
DATE RECEIVED BY LOCAL REGISTRAR NOV 4 - 1950			REGISTRAR'S SIGNATURE Huntington Williams, Md.			25. FUNERAL DIRECTOR Elizabeth Harle Inc.			ADDRESS 115 E. West St.		

0510 02

0510



416
50 9451BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9451

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Butishica Oliver

2. DATE
OF
DEATH

November 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore 16-01

C. Length of stay in Baltimore

6 month

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

914 Carrollton Ave. N.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

Female

Colored

Widowed

- - 78

72

10A. USUAL OCCUPATION (Give kind of
work done during most of working life even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

Housewife

Summerton S.C

U.S.A.

13. FATHER'S NAME

Jake McBride

14. MOTHER'S MAIDEN NAME

Sally

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK22. I hereby certify that I attended the deceased from 10-29, 1950, to 11-1, 1950 that I last saw the
deceased alive on 11-1, 1950, and that death occurred at 5 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

H. E. Langford

M. D.

JOHNS HOPKINS HOSPITAL

11/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Shipped

11-4-1950

Summerton S.C.

S.C.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

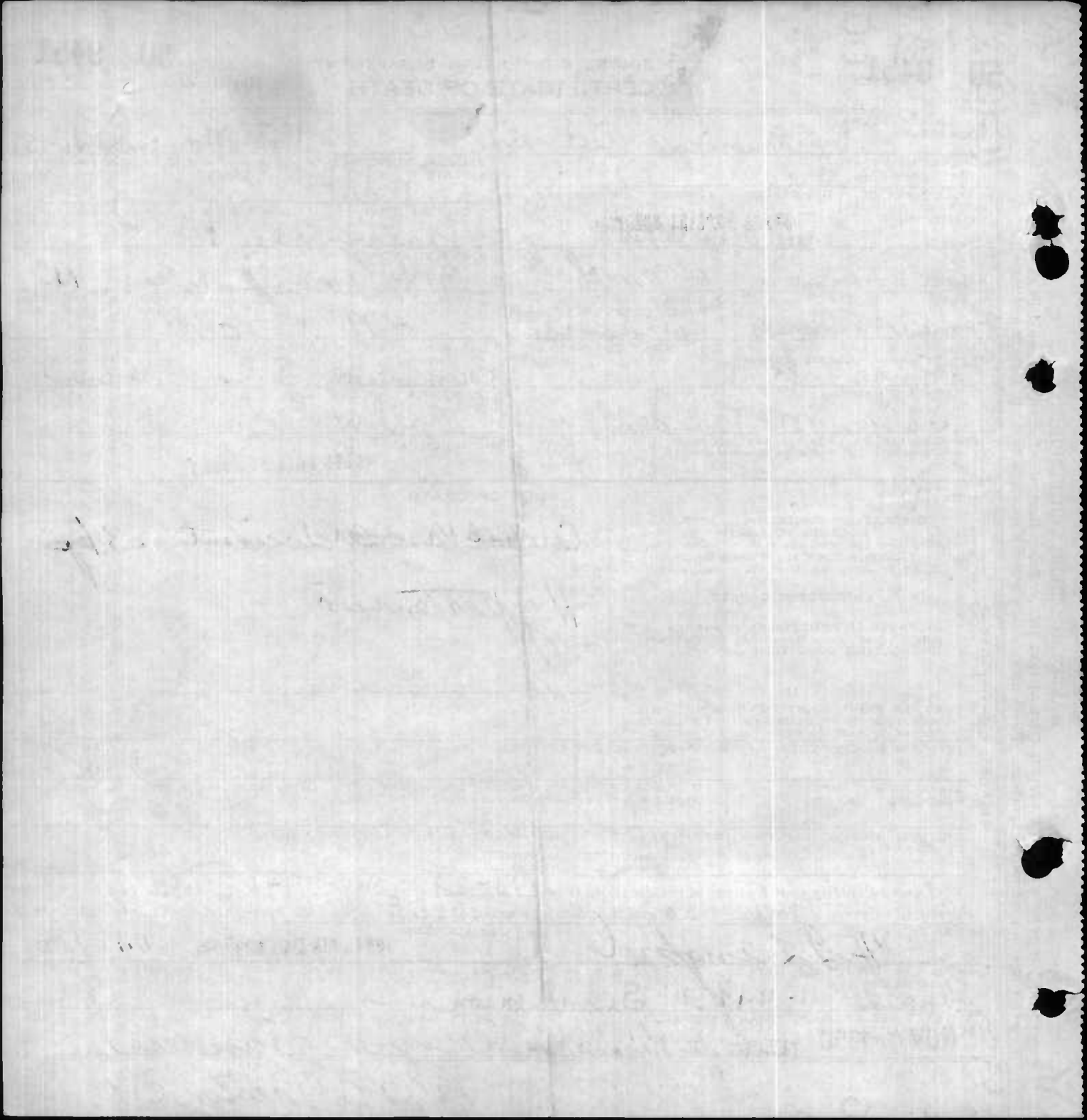
25. FUNERAL DIRECTOR

ADDRESS

NOV 4 - 1950

Ruthington Williams, M.D.

Rayner Sanders



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9452****50 9452**

1. NAME OF DECEASED (Type or Print) <i>Elizabeth Monk</i>			2. DATE OF DEATH <i>11-3-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Balt.</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>3107 Chesley Ave</i>			C. CITY OR TOWN (If outside corporate limits, state full name and give township) <i>Balt.</i>		
c. Length of stay in Baltimore Yrs. <i>00</i> Mos. <i>27</i> Days <i>-05</i>			D. STREET ADDRESS (If rural, give location) <i>3107 Chesley Ave</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S</i>	8. DATE OF BIRTH <i>Nov. 28-1889</i>	9. AGE (In years, last birthday) <i>80</i>	10. Under 1 Year Months: <i>0</i> Days: <i>0</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>England</i>	
13. FATHER'S NAME <i>William H. Monk</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Ambrose</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs. Mac Gardner</i>	
				ADDRESS <i>3107 Chesley Ave</i>	

18. *422.1*DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

*10/30/50**?*19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *June 30, 1943* to *Nov. 3, 1950*, that I last saw the deceased alive on *Nov. 3, 1950*, and that death occurred at *5 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

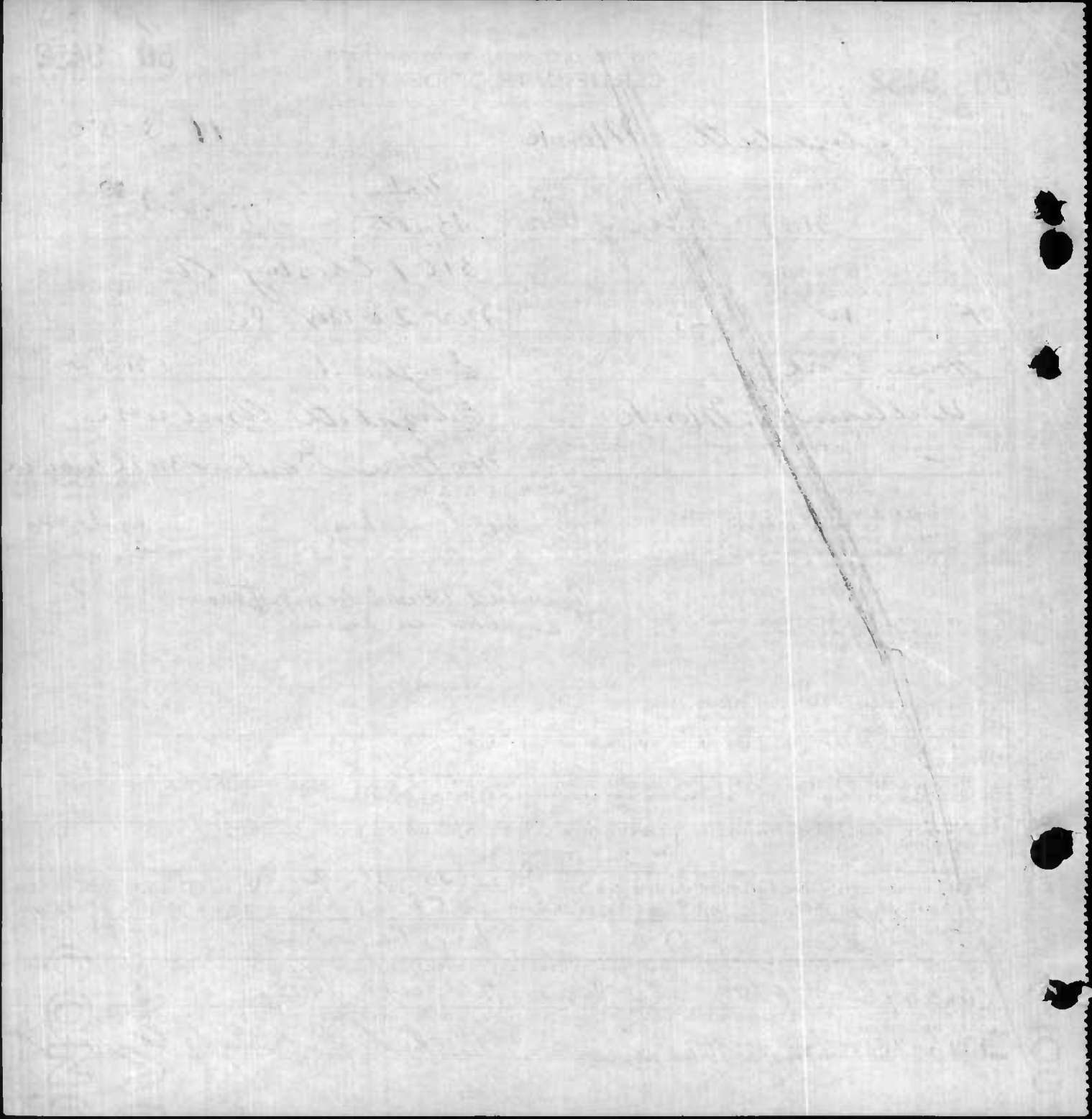
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*NOV 4 - 1950**Mildred J. Blight 6009 Hayford Rd**938*



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9453**

BIRTH NO. 50-21945		1. NAME OF DECEASED (Type or Print) Danny DIGGS		2. DATE OF DEATH Oct. 31, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 4-02			
B. FULL NAME OF (If not in hospital or institution, give street address or location) 725 W. Fayette St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 725 W. Fayette St.			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Oct. 16, 1950	9. AGE (In years last birthday) 14	10. Under 1 Year Months: Days: 14
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Herbert Hashins		14. MOTHER'S MAIDEN NAME Emma Diggs.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Emma Diggs, 725 W. Fayette St.	
18. 76301 CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Interstitial Pneumonia					
DUE TO					
ANTECEDENT CAUSES (B)					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)					
DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley S. Dencosher M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR		23C. DATE SIGNED Oct. 31, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-1950		24C. NAME OF CEMETERY OR CREMATORY Wt Zion Cem Balto.	
24D. LOCATION (City, town, or county) (State) Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE Wmington Williams, M.D.	
25. FUNERAL DIRECTOR Mr. Kati R. Williams		25. ADDRESS Schroeder St 322 N			

NOV 4 - 1950
VS 151

108 ✓

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

DATE OF DEATH

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9454
Registered No. _____

B-530
50 9454
BIRTH NO. 131483

1. NAME OF DECEASED (Type or Print) Odie Bond			2. DATE OF DEATH Oct. 28, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
5. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 1403 Harford Avenue		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH April 11, 1884	9. AGE (In years last birthday) 66	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Construction Work	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME Joshua Bond			14. MOTHER'S MAIDEN NAME Harriet Bond		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Records: B. C. H. 4940 Eastern Avenue		

18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Polycystic Kidneys Bilateral			INTERVAL BETWEEN ONSET AND DEATH over two years
DUE TO (A) _____			over 2 years
DUE TO (B) _____			
DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis Heart Disease			
19A. DATE OF OPERATION 2	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-30 , 1949 , to 10-28 , 1950 , that I last saw the deceased alive on 10-28 , 1950 , and that death occurred at 10:50 A.M. , from the causes and on the date stated above.			
23A. SIGNATURE <i>[Signature]</i>	23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 11-3-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 11-4-50	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) Mt. Auburn
DATE RECEIVED BY LOCAL REGISTRAR NOV 4-1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR ADDRESS LaPorte & Sons 1014 E. Edmonson Ave	

VS 150

97024

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF OHIO

1910

1000

1000

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9455
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Dora Hooven			2. DATE OF DEATH Nov. 3, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____		
5. FULL NAME OF HOSPITAL OR INSTITUTION 00 6213 Danville Ave.			C. CITY OR TOWN (If outside corporate limits, write rural and give township) Baltimore		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 6213 Danville Ave.		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 18, 1866	9. AGE (In years last birthday) 84	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME Philip Beck			14. MOTHER'S MAIDEN NAME not known		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS Mrs. R.C. McNew 6213 Danville Ave.		

MEDICAL CERTIFICATION	18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Myocarditis acute	INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	ANTECEDENT CAUSES		Arteriosclerosis, chronic	
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 1948 , to Nov. 3, 1950 , that I last saw the deceased alive on Nov. 2, 1950 , and that death occurred at 8:45 m., from the causes and on the date stated above.					
23A. SIGNATURE Dora H. McNew		23B. ADDRESS 33 W. 14th Ave. Dundalk, Md.		23C. DATE SIGNED 11/3/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 6, 1950		24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel	
24D. LOCATION (City, town, or county) (State) Baltimore		25. FUNERAL DIRECTOR Harold T. Hoffman			
DATE RECEIVED BY LOCAL REGISTRAR NOV 4 - 1950		REGISTRAR'S SIGNATURE Huntington Williams		ADDRESS 1639 Broadway	

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Andrew
Dunstable and

Johnson
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9456
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHNSON, PAUL

2. DATE
OF
DEATH

11-3-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

FRANKLIN SQ HOSP.

C. CITY OR TOWN

BALTIMORE

D. STREET ADDRESS (If rural, give location)

19. S CAREY

c. Length of stay in Baltimore

11

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

2-28-1908

9. AGE (In years last birthday)

42

10 Under 1 Year Months Days

8 3

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BARTENDER

10B. KIND OF BUSINESS OR INDUSTRY

TAVERN

11. BIRTHPLACE (State or foreign country)

W. VA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

T.M. JOHNSON

14. MOTHER'S MAIDEN NAME

SARA QUERDAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

BOLDIE JOHNSON

18. 592X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA, ACUTE

3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) LOWER NEPRON NEPHROSIS 3 days

DUE TO

II

(C) TRANSFUSION REACTION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10-30-50

19B. MAJOR FINDINGS OF OPERATION

SUBTOTAL GASTRECTOMY

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-21, 1950 to 11-3, 1950, that I last saw the deceased alive on 11-3, 1950 and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. B. B. B.

M. D.

23B. ADDRESS

Franklin Sq. Hosp.

23C. DATE SIGNED

11-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 4 - 1950

Huntington Williams, M.D.

Nancy H. Hylke

4101 Columbia

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Burial		18. Signature of Interment	
19. Signature of Burial		20. Signature of Interment		21. Signature of Burial	
22. Signature of Interment		23. Signature of Burial		24. Signature of Interment	
25. Signature of Burial		26. Signature of Interment		27. Signature of Burial	
28. Signature of Interment		29. Signature of Burial		30. Signature of Interment	
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91. Signature of Burial		92. Signature of Interment		93. Signature of Burial	
94. Signature of Interment		95. Signature of Burial		96. Signature of Interment	
97. Signature of Burial		98. Signature of Interment		99. Signature of Burial	
100. Signature of Interment		101. Signature of Burial		102. Signature of Interment	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-225

M-25959457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

9457

1. NAME OF DECEASED (Type or Print) McGuigan AMELIA M. MCGUGAN			2. DATE OF DEATH November 4, 1950		
3. PLACE OF DEATH: Baltimore City, Maryland Baltimore			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
5. FULL NAME OF HOSPITAL OR INSTITUTION 327 E. Belvedere Avenue			6. STREET ADDRESS (If rural, give location) 327 E. Belvedere Avenue		
c. Length of stay in Baltimore 32 Yrs. 0 Mos. 0 Days			7. DATE OF BIRTH 1-14-1886		
8. SEX female	9. COLOR OR RACE white	10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	11. AGE (In years last birthday) 64		12. CITIZEN OF WHAT COUNTRY? 11 Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME Geo. Emerling			14. MOTHER'S MAIDEN NAME Mary Hoffman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Wm. L McGuigan			ADDRESS 327 E. Belvedere Ave.		

18. **E 900.6**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Left subdural hemorrhage**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myeloid leukemia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIB-UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
office21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
828 Park Avenue21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
November 3, 1950 3-4p m.21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒21F. HOW DID INJURY OCCUR?
Tripped over small step & fell to floor

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Rammer, D.

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Nov. 4, 195024A. BURIAL, CREMA-TION, REMOVAL (Specify)
Burial

24B. DATE

11-7-1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county) (State)

Lackawanna, New York

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Rammer, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John A. Moran 3000 E. Baltimore St.

VS 151

N 854.2**186a**

1947

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1947

1. Name of the plant or animal		2. Name of the collector	
3. Locality		4. Date	
5. Description of the specimen		6. Remarks	
7. Number of specimens		8. Name of the institution	
9. Name of the collector		10. Name of the collector	
11. Name of the collector		12. Name of the collector	
13. Name of the collector		14. Name of the collector	
15. Name of the collector		16. Name of the collector	
17. Name of the collector		18. Name of the collector	
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95. Name of the collector		96. Name of the collector	
97. Name of the collector		98. Name of the collector	
99. Name of the collector		100. Name of the collector	

N-216

CERTIFICATE CORRECTED 12-15-50

50 9458

BALTIMORE CITY HEALTH DEPARTMENT

50 9458

BIRTH NO. 50-24343

CERTIFICATE OF DEATH

X Registered No.

1. NAME OF DECEASED (Type or Print) BABY BOY NEIGHBORS			2. DATE OF DEATH Nov. 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Union Memorial Hosp.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Monkton, Md. B. COUNTY Baltimore County		
B. FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location)		
5. SEX m	6. COLOR OR RACE w	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) s	8. DATE OF BIRTH 11/4/50	9. AGE (In years last birthday)	If Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John O. Neighbors			14. MOTHER'S MAIDEN NAME Mary Jane Neighbors		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Father		ADDRESS

18. 760.0	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage DUE TO SUBDURAL HEMATOMA - left	
ANTECEDENT CAUSES	(B) Birth Injury DUE TO Fractured parietal Bone	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) left	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11/4/50 to 11/4/50 , that I last saw the deceased alive on 11/4/50 , and that death occurred at 6:08 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE W. W. Gray		23B. ADDRESS 1014 1st Pave St Bulbo (2)		23C. DATE SIGNED 11/4/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE Nov. 4, 1950		24C. NAME OF CEMETERY OR CREMATORY St. James	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Thurston Williams, M.D.		25. FUNERAL DIRECTOR Samuel M. Brooks, Inc., Md	

VS 150

160a

1218 02



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-524 50 9459		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 9459 Registered No.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>De Angelis, Lucy Esther</u>			2. DATE OF DEATH <u>November 2, 1950</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore <u>41</u> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>3527 Claremont St.</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/29/91</u>	9. AGE (In years last birthday) <u>59</u>	10. Under 1 Year: Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Edward Tatta</u>			14. MOTHER'S MAIDEN NAME <u>Cecilia</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Roger De Angelis 3527 Claremont St.</u>		
18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary thrombosis</u> DUE TO <u>coronary artery arterio-sclerosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Hypertension</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>November 1, 1950</u> to <u>November 2, 1950</u> , that I last saw the deceased alive on <u>Nov. 1, 1950</u> , and that death occurred at <u>5:30^{PM}</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Thaddeus S. Swinski</u>		23B. ADDRESS <u>1400 N. Caroline St.</u>		23C. DATE SIGNED <u>Nov. 2, 1950</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov. 6 1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) <u>4430 Belair Rd.</u>		24E. DATE RECEIVED BY LOCAL REGISTRAR <u>Nov 5 - 1950</u>		24F. REGISTRAR'S SIGNATURE <u>Thaddeus S. Swinski</u>	
24G. FUNERAL DIRECTOR <u>Frank Della Loe</u>		24H. ADDRESS <u>22 S. High St.</u>		24I. DATE RECEIVED BY LOCAL REGISTRAR <u>Nov 5 - 1950</u>	

50 3151

DATE OF DEATH

50 3151

Form 101

U.S.

WILLIAMSON, Ed.

WILLIAMSON, Ed.

WILLIAMSON, Ed. 1910 1910 1910 1910

WILLIAMSON, Ed. 1910 1910 1910 1910

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-651
50 9460BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9460

Registered No. 4

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Harry Greenbaum,

2. DATE
OF
DEATH

Nov 4rd. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Madison Aprt.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

c. Length of stay in Baltimore Lifetime,

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

Madison Aprt. 817 St. Paul St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

Aug. 10th. 1869. 81

9. AGE (In years
last birthday)10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
Dr.10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Emanuel Greenbaum

14. MOTHER'S MAIDEN NAME

Kerngood,

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. R. H. Greenbaum

Madison Aprt.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

DUE TO

(A) Coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B) Angina pectoris
Generalized arteriosclerosis

15 years-

years-

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Oct. 1925 to Nov. 3, 1950, that I last saw the
deceased alive on Oct. 1950, and that death occurred at 6:44 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Louis P. Hamburger M. D.

23B. ADDRESS

1207 Eutaw Pl.

23C. DATE SIGNED

3 Nov 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 5th. 1950 Balto? Hebrew

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

Balto?md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Washington Williams, M.D.

1902 Eutaw Pl

NOV 5 - 1950
VS 150

94a

0880 02

CERTIFICATE OF DEATH

0880 02

68.41

H-655
50

9461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9461

Registered No. 3

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Ernest HERMAN		2. DATE OF DEATH Nov. 3th. 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 5013 Gwyne Oak Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION 5013 Gwyne Oak Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore 40Yrs.		D. STREET ADDRESS (If rural, give location) 5013 Gwyne Oak Ave			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 21st. 1874.	9. AGE (In years, last birthday) 75	10. Under 1 Year Months: 10 Days: 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Coll.		10B. KIND OF BUSINESS OR INDUSTRY Insurance.		11. BIRTHPLACE (State or foreign country) Marshal Mo.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Solomon Herman		14. MOTHER'S MAIDEN NAME Pauline Alham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 2-17-81-22 04		17. INFORMANT 5013 Mrs. Hortense McCoyGyneOak.	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion		CAUSE OF DEATH (A) Coronary occlusion DUE TO (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 hrs?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1941 to 11/3 , 19 50 , that I last saw the deceased alive on 9/18 , 19 50 , and that death occurred at 5 30 m., from the causes and on the date stated above.					
23A. SIGNATURE Robert A. Reiter		23B. ADDRESS 3408 W. Windsor Ave		23C. DATE SIGNED 11/7/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 6th 1950		24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship	
24D. LOCATION (City, town, or county) Balto. Md.		25. FUNERAL DIRECTOR David Sullivan & Son		ADDRESS 1902 #utaw Pl.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 5 - 1950		REGISTRAR'S SIGNATURE William M. Williams			

1918 3161

505 1461

CERTIFICATE OF DEATH

1918 3161

505 1461

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

1918

CERTIFICATE OF DEATH

1918 3161

CERTIFICATE OF DEATH

B-40050 9462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9462

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD L. BELL

2. DATE
OF
DEATH

NOV 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

3714 FALLS ROAD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

BALTIMORE

13-08

D. STREET ADDRESS (If rural, give location)

3714 FALLS ROAD

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

APRIL 15, 1906

9. AGE (In years,
last birthday)

44

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

CHAUFFEUR

10B. KIND OF BUSINESS OR
INDUSTRY

CONSOLIDATED BEEF CO. (W)

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

217-01-7785

17. INFORMANT

ADDRESS

ANNA BELL 3714 FALLS ROAD

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) ...
DUE TO

Coronary Thrombosis

1/2 Hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) ...
DUE TO

Coronary Artery Disease

II

(C) ...

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov-4, 1950, to Nov 4, 1950, that I last saw the
deceased alive on 19, and that death occurred at 2:30 m., from the causes and on the date stated above.

23A. SIGNATURE

Edward L. Hammer

M. D.

23B. ADDRESS

4037 Falls Rd

23C. DATE SIGNED

11/4/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Nov 7/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county)

Taylor Ave

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

John Williams M.D.

25. FUNERAL DIRECTOR

ADDRESS

Theodore E. Donovan 3818 Roland

NOV 5 - 1950

NOV 5 1950

66363

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

540 06

540 06

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 07-11-01 BY SP-10/UC

1. The purpose of this document is to provide a summary of the information received from the source.

2. The information received from the source is as follows:

3. The information received from the source is as follows:

4. The information received from the source is as follows:

5. The information received from the source is as follows:

6. The information received from the source is as follows:

7. The information received from the source is as follows:

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9. The information received from the source is as follows:

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18. The information received from the source is as follows:

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21. The information received from the source is as follows:

22. The information received from the source is as follows:

23. The information received from the source is as follows:

24. The information received from the source is as follows:

25. The information received from the source is as follows:

26. The information received from the source is as follows:

27. The information received from the source is as follows:

28. The information received from the source is as follows:

29. The information received from the source is as follows:

30. The information received from the source is as follows:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-000
JL-142720

50 9463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9463
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Wing Sue Lee		2. DATE OF DEATH 11-4-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-10	
c. Length of stay in Baltimore ? Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 5307 York Rd.	
5. SEX Male	6. COLOR OR RACE White (Chinese)	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH ? ? ?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY MAN		10B. KIND OF BUSINESS OR INDUSTRY LAUNDRY	9. AGE (In years last birthday) 60
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT B. C. H. Records, 4940 Eastern Ave.		ADDRESS	

18. 332X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Artriosclerosis DUE TO		Years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus		Years
19A. DATE OF OPERATION ?	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 10-21-50 , 19 ? , to Nov. 4 , 19 50 that I last saw the deceased alive on Nov. 4 , 19 50 , and that death occurred at 4.45 AM from the causes and on the date stated above.		
23A. SIGNATURE Ch. Boym M. D.	23B. ADDRESS Baltimore City Hospital 4940 Eastern Ave.	23C. DATE SIGNED Nov. 4, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov 7/50	24C. NAME OF CEMETERY OR CREMATORY Lorraine
24D. LOCATION (City, town, or county) (State) Woodlawn	25. FUNERAL DIRECTOR Stewart Morris. Ball ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR Nov 5 - 1950	REGISTRAR'S SIGNATURE Wm. Williams, M.D.	

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H-50° 9464

50 9464

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

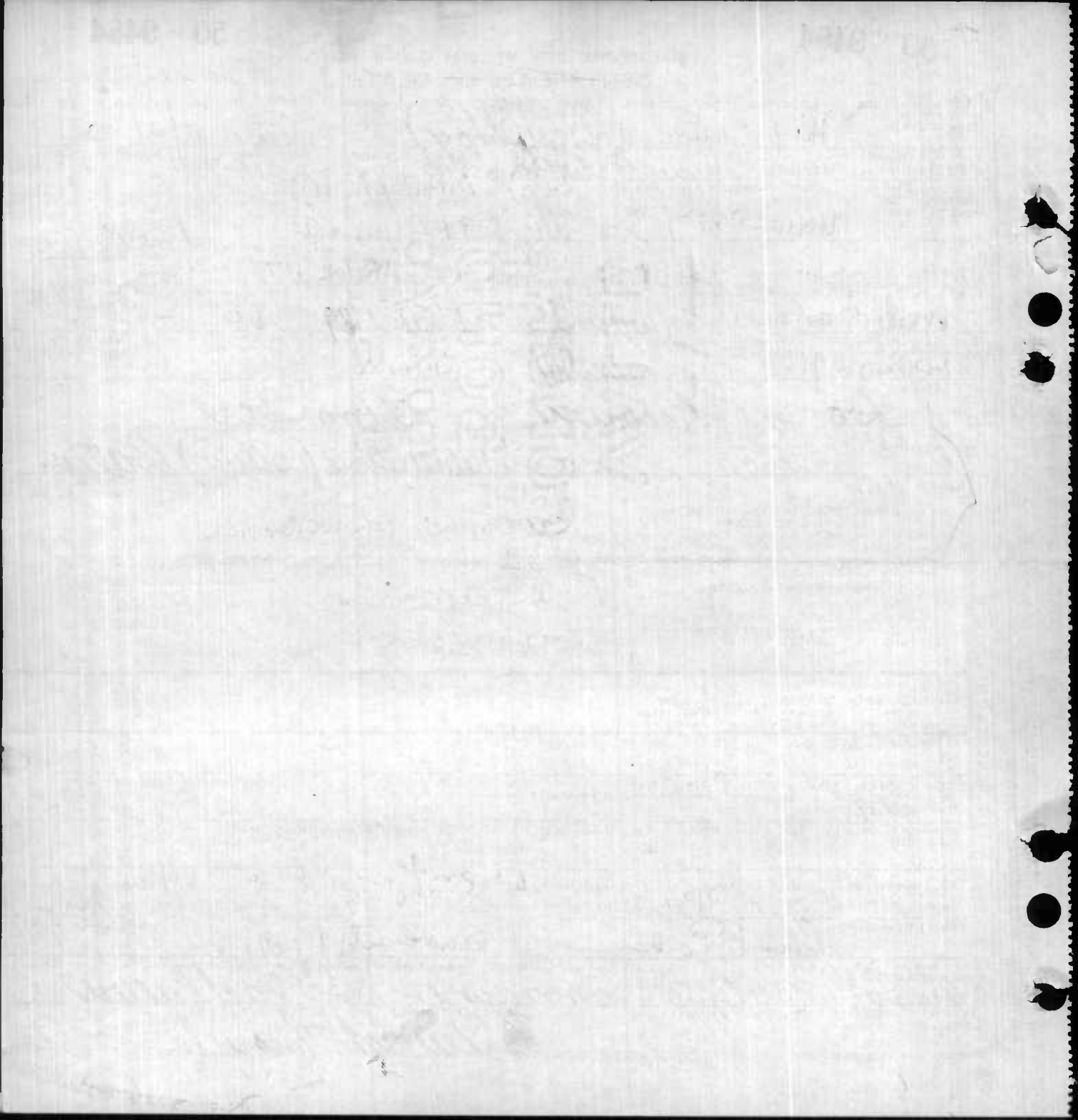
Registered No. _____

BIRTH NO. _____			
1. NAME OF DECEASED (Type or Print) HOY, LIEU (Lieu Hoy)		2. DATE OF DEATH 11/2/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Grune Redwood		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION UNION QST		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE	
c. Length of stay in Baltimore about 40		D. STREET ADDRESS (If rural, give location) 14 W. ARINGTON AVE	
5. SEX Male	6. COLOR OR RACE ORIENTAL	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH about 1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY	10B. KIND OF BUSINESS OR INDUSTRY Laundry	9. AGE (in years last birthday) 61	11. BIRTHPLACE (State or foreign country) CHINA
13. FATHER'S NAME Not known	12. CITIZEN OF WHAT COUNTRY? _____	14. MOTHER'S MAIDEN NAME Hoo Sen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT David Liu (cousin) ADDRESS Balto.	
18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE DUE TO ANTECEDENT CAUSES HYPERTENSION DUE TO DIABETES			INTERVAL BETWEEN ONSET AND DEATH _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from 6:00 PM 11/2/50 , to 8:20 , 19 11/2 , that I last saw the deceased alive on 2:00 PM 11/2/50 , and that death occurred at 8:20 m., from the causes and on the date stated above.			
23A. SIGNATURE Leonard Bach M.D.		23B. ADDRESS University Heights	23C. DATE SIGNED _____
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 200/6/50	24C. NAME OF CEMETERY OR CREMATORY Lorraine	24D. LOCATION (City, town, or county) (State) Woodlawn
DATE RECEIVED BY LOCAL REGISTRAR _____	REGISTRAR'S SIGNATURE _____	25. FUNERAL DIRECTOR Stewart Mowen Co. - Balto. ADDRESS _____	

NOV 5 - 1950

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C-600
50 9465BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9465

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

George Albert Carr

2. DATE
OF
DEATH

Nov. 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Provident Hosp.

D. STREET ADDRESS (If rural, give location)

2413 Etting St.

c. Length of stay in Baltimore

27 Yrs.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 22, 1893

9. AGE (In years)

56 57 Yrs.

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Private

11. BIRTHPLACE (State or foreign country)

Easton, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander Carr

14. MOTHER'S MAIDEN NAME

Sarah Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Wyoelia Carr-2413 Etting St.

18.

521X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-25, 1950, to 11-3, 1950, that I last saw the deceased alive on 11-3, 1950, and that death occurred at 10:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 7, 1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Cem.

24D. LOCATION (City, town, or county)

Baltimore Co, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 5 - 1950

Huntington Williams, M.D.

Holland

Funeral Home-1631 Druid Hill Ave.

6828A

1147

1948

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1948

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information supplied, The correct age is especially important. Physicians: please write the causes of death clearly and

N-425
50 9466BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH.

Dr. J. 50 9466

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mildred Viola Nelson

2. DATE

OF
DEATH Nov, 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

416 Watty Ct.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

416 Watty Ct.

c. Length of stay in Baltimore

33 Yrs.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

Dec. 24, 1917

9. AGE (In years last birthday)

32 33

10 Under 1 Year Months Days
11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Richard Jenifer

14. MOTHER'S MAIDEN NAME

Viola Hasty

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
220-22-9531

17. INFORMANT

ADDRESS

Mr. Anthony Nelson-416 Watty Ct.

18. 002X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.The advanced, bilateral
Pulmonary Tuberculosis
C. Pulmonary Hemorrhage
As direct cause.INTERVAL BETWEEN
ONSET AND DEATH

4 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT

NOT WHILE

WORK

AT WORK

I hereby certify that I attended the deceased from Jan 14, 1950, to Nov 7, 1950, that I last saw the deceased alive on Dec 9, 1950, and that death occurred at 11:00 m., from the causes and on the date stated above.

SIGNATURE

Thurston R. Julian

M. D.

23B. ADDRESS

1207 Madison Ave.

23C. DATE SIGNED

11/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 6, 1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston R. Julian

25. FUNERAL DIRECTOR

Holland

ADDRESS

Funeral Home-1631 Druid Hill Ave.

NOV 5 1950

13B

3000

3000

to the same place
the same place
the same place
the same place

the same place

the same place
the same place
the same place

the same place
the same place
the same place

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9467
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lewis Johnson

2. DATE
OF
DEATH

November 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

US Marine Hospital

Baltimore 11, Maryland

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1137 Park Avenue

c. Length of stay in Baltimore

Life

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 1898

9. AGE (In years last birthday)

52

10 Under 1 Year

Months Days

11 Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Watchman

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Johnson

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

--

17. INFORMANT

ADDRESS

Records - US Marine Hospital, Balto., Md.

18.

190x

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

Malignant melanoma

DUE TO

with metastases to heart, lung, liver, spleen, kidneys, adrenals, pancreas, stomach, large intestine, small intestine, prostate, bone and skin.

(B)

DUE TO

Perforation of small intestine with peritonitis, generalized.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

3 months

days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Oct. 9**, 19 **50**, to **Nov. 2**, 19 **50**, that I last saw the deceased alive on **Nov. 2**, 19 **50**, and that death occurred at **10 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE

Richard G. Saavedra

23B. ADDRESS

23C. DATE SIGNED

John L. Wilson, Clinical Dir., Med. Dir.

U.S. Marine Hospital, Balto., Md. 11-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 7, 50

24C. NAME OF CEMETERY OR CREMATORY

Belair Cemetery

24D. LOCATION (City, town, or county)

Belair Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Nov 5 - 1950

William M. Gibson

Geo. T. A. Gibson Sr.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,
January 1, 1917.

REPORT
OF THE
ATTORNEY GENERAL,
JAMES C. CLARK,
FOR THE YEAR
1916.

ALBANY:
JAMES B. CLARK,
PRINTERS,
1917.

THE STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
JAMES C. CLARK,
ATTORNEY GENERAL,
ALBANY, N. Y.

REPORT
OF THE
ATTORNEY GENERAL,
JAMES C. CLARK,
FOR THE YEAR
1916.

ALBANY:
JAMES B. CLARK,
PRINTERS,
1917.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 9468
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

12-21-1883

9. AGE (In years last birthday)

66

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARM LABORER

10B. KIND OF BUSINESS OR INDUSTRY

FARMING

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William H. Fleming

14. MOTHER'S MAIDEN NAME

Susan Mullinix

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Robert Fleming, Sykesville, Md

ADDRESS

18.

241X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Asthma, Pul. Edema.

Embolie Phenomenon.

Heart failure

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-1-50, 19, to 11-5-50, 19, that I last saw the deceased alive on 11-5-50, 19, and that death occurred at 6:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph B. Brumaker

23B. ADDRESS

Crisp Harp.

23C. DATE SIGNED

11-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

11-8-1950

24C. NAME OF CEMETERY OR CREMATORY

MORGAN Chapel

24D. LOCATION (City, town, or county)

CARROLL Co.

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

NOV 6 - 1950

REGISTRAR'S SIGNATURE

Huntington Williams, Md.

25. FUNERAL DIRECTOR

B. M. Waltz

ADDRESS

Winfield, Md.



CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 9469

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM C. J. TURNER JR.

2. DATE OF DEATH
Nov. 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE Baltimore City Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Towson 5300

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)
8529 8521 Willow Oak Rd.

5. SEX

Male

White

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/16/1921

9. AGE (In years last birthday)

29

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

Artway Cab Co.

11. BIRTHPLACE (State or foreign country)

Balt. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm C. Turner Sr

14. MOTHER'S MAIDEN NAME

Eva M. Leitch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

W. W. 1918

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Eliz McCrone Harrisburg Pa

18. E812.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Skull fracture

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Subdural Hemorrhage

DUE TO

(C) Contusion of brain

Fracture of right tibia and fibula

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
O'Donnell St. near Steelton Ave. 26/6

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
Nov. 3, 1950 12 midnite m.

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? (stepped from cab. Pedestrian hit by auto to street)

22. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William W. Smith

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ M.D. MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED
Nov. 3, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/6/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine

24D. LOCATION (City, town, or county) (State)

Balt. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

NOV 6 1950

REGISTRAR'S SIGNATURE

William W. Smith

25. FUNERAL DIRECTOR

Wm Cook Inc. 1217 St. Paul St.

ADDRESS

V S 151

N 804.2

68254

170C

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and

THE BOARD OF HEALTH
CITY OF BOSTON
CERTIFICATE OF DEATH

CAUSE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9470****50 9470**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mildred V. Myers			2. DATE OF DEATH Nov. 3, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 25-06		
B. FULL NAME OF HOSPITAL OR INSTITUTION 3423 Sunlea Court, Fairfield			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. 00 Mos. 00 Days 00			D. STREET ADDRESS (If rural, give location) 3423 Sunlea Court, Fairfield		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 1906		9. AGE (in years last birthday) 44 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME William Gartside		
14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mr. Earl A. Myers, 3423 Sunlea Court		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion DUE TO Hypertensive - C.V. Disease DUE TO Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH one day
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 1, 1950 to Nov. 2, 1950 , that I last saw the deceased alive on Nov. 2, 1950 , and that death occurred at 44-m. , from the causes and on the date stated above.					
23A. SIGNATURE Paul Rubin		23B. ADDRESS M. D. 320 Lafayette Ave -		23C. DATE SIGNED 11/4/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 11/6/50		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Ritchie Highway, A.A. Co., MD		25. FUNERAL DIRECTOR Wm. Cook, Jr. & Co.		ADDRESS 1217 St. Paul Street	

30 MAY

30 MAY

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9471

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)ROSE SNESIK2. DATE
OF
DEATHNov 6 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland5. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONSinai HospitalC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)Baltimore

D. STREET ADDRESS (If rural, give location)

3812 Park Heights Ave

c. Length of stay in Baltimore

55 Yrs

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

18659. AGE (In years
last birthday)85

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)House Wife10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Austria12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jacob Schreiber

14. MOTHER'S MAIDEN NAME

Hanna ?15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Mr Joseph D Stark 3812 Park Heights Ave18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

arteriosclerotic
myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

arteriosclerotic heart disease

(C)

diabetes mellitusII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 30, 1950, to Nov 6, 1950, that I last saw the
deceased alive on Nov 6, 1950, and that death occurred at 6:0 A m., from the causes and on the date stated above.

23A. SIGNATURE

Frank E. White M. D.

23B. ADDRESS

Sinai Hosp

23C. DATE SIGNED

Nov 624A. BURIAL, CREMA-
TION, REMOVAL (Specify)Burial

24B. DATE

Nov 7, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mogen Abraham Cong Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY
LOCAL REGISTRARNOV 6 - 1950

REGISTRAR'S SIGNATURE

James J. Williams, M.D.

25. FUNERAL DIRECTOR

Sol. J. Williams, 1126 W North Ave

ADDRESS

A-3 46
50 9472

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

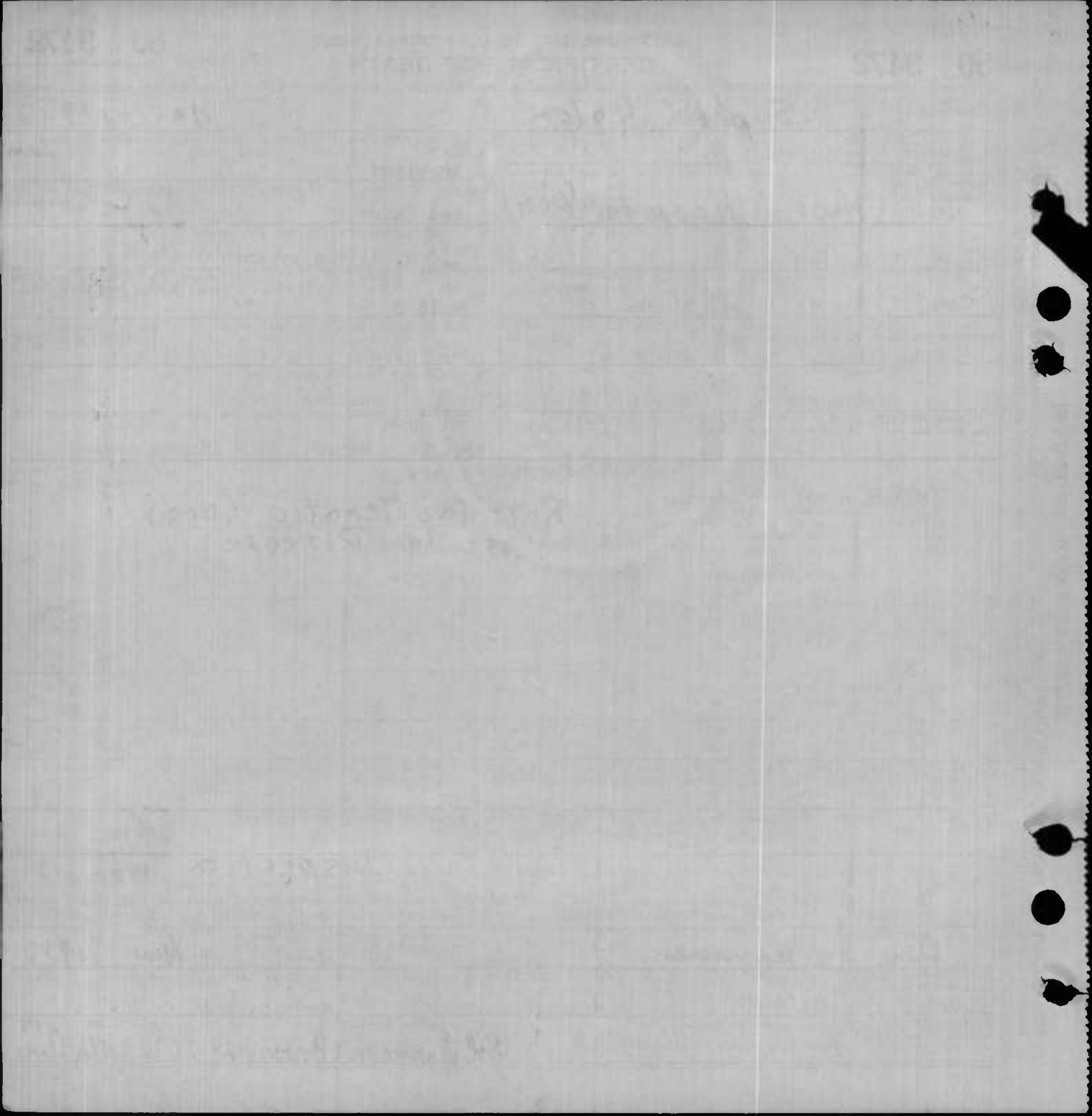
Registered No. 50 9472

1. NAME OF DECEASED (Type or Print) Sophie Adler		2. DATE OF DEATH Nov. 5, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOR)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) 150 N. Milton Avenue	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 74
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Russia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? Russia	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Unknown	
17. INFORMANT Mrs. Dora Merkel		ADDRESS 1902 Linden Avenue	

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH
CAUSE OF DEATH DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23a. SIGNATURE Wm. H. Kammer, Jr.	23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR	23c. DATE SIGNED Nov. 5, 1950
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/6/50	24c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol
24d. LOCATION (City, town, or county) (State) Rosedale, Balto., Md.	25. FUNERAL DIRECTOR Sol Levinson & Bros. 1124-26 W. North Ave.	
24e. DATE RECEIVED BY LOCAL REGISTRAR Nov 6 - 1950		24f. REGISTRAR'S SIGNATURE William H. Kammer, Jr.

093 d

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-510 50 9473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

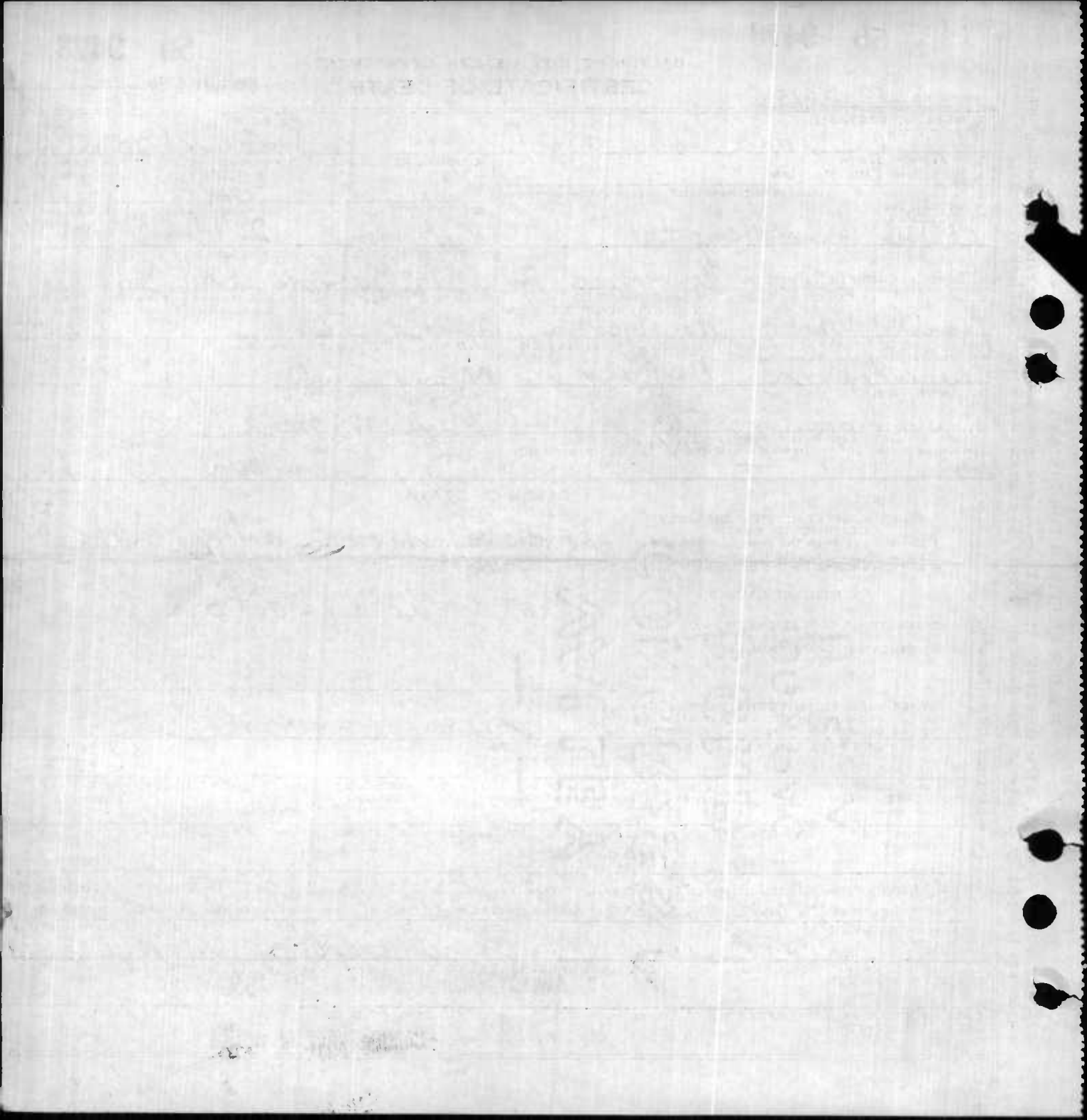
50 9473

Registered No. _____

BIRTH NO. 50-23186

1. NAME OF DECEASED (Type or Print) <u>Cumboa, baby girl</u>			2. DATE OF DEATH <u>Oct 25, 50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balt.</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home & Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>27-38</u>		
c. Length of stay in Baltimore <u>Newborn</u>			D. STREET ADDRESS (If rural, give location) <u>1314 Ramblewood Rd.</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Newborn</u>	8. DATE OF BIRTH <u>25 Oct 50</u>		9. AGE (In years last birthday) Months: Days <u>2</u> <u>48</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Newborn</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Cumboa, Mr Tay</u>			14. MOTHER'S MAIDEN NAME <u>Powell, Jeannette</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>_____</u>	17. INFORMANT ADDRESS <u>Tay Cumboa 1314 Ramblewood</u>		

18. <u>761.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiovascular & respiratory collapse</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 48 min</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Past cesarean section</u>			DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Suprarenal hemorrhage</u>			(C) _____		
19A. DATE OF OPERATION <u>2</u>		19B. MAJOR FINDINGS OF OPERATION <u>_____</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>_____</u>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>_____</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>_____</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>_____</u>		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>_____</u>	
22. I hereby certify that I attended the deceased from <u>25 Oct 50</u> , 19 <u>50</u> , to <u>25 Oct 50</u> , that I last saw the deceased alive on <u>25 Oct</u> , 19 <u>50</u> , and that death occurred at <u>2:15 P</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Dorrence Currier</u>		23B. ADDRESS <u>Church Home & Hosp Balt.</u>		23C. DATE SIGNED <u>31 Oct 50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>_____</u>		24B. DATE <u>NOV 6 - 1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>JOHN HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State) <u>NOV 1 1950</u>		25. FUNERAL DIRECTOR <u>Commissioner of Health</u>		ADDRESS <u>_____</u>	



50 9474 BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH Registered No. 4071212

BIRTH NO. 50-23647

1. NAME OF DECEASED (Type or Print) <i>Baby girl Clark "J"</i>		2. DATE OF DEATH <i>10-28-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>University Hospital</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-02</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1811 N. Palisade Ave.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>B.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>10-28-50</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>10 55</i>
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Clark</i>		14. MOTHER'S MAIDEN NAME <i>E. Thel Fleming</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS <i>↑</i>	

18. <i>776x</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>prematurity</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <i>✓</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>10/28</i> , 19 <i>50</i> , to <i>10/28</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>10/28</i> , 19 <i>50</i> , and that death occurred at <i>J. H. M.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>J. E. Jernan</i>	23B. ADDRESS M. D. <i>University Hospital</i>	23C. DATE SIGNED <i>10/28</i>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY <i>JOHN HOPKINS MEDICAL SCHOOL NOV 1 1950</i>
24D. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR <i>Commissioner of Health</i>	ADDRESS
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 6 - 1950</i>	REGISTRAR'S SIGNATURE <i>William B. Williams</i>	

VS 150 159.0

F. 616

50 9475

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9475

Registered No.

BIRTH NO. 50-23970

1. NAME OF DECEASED
(Type or Print)

BABY BOY FIEBURGER

2. DATE
OF
DEATH

11-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore 26-34

D. STREET ADDRESS (If rural, give location)

956 Quantrel St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Male

White

8. DATE OF BIRTH

11-1-50

9. AGE (In years
last birthday)

Newborn

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

1 19

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Newborn

10B. KIND OF BUSINESS OR
INDUSTRY

Newborn

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Fieburger, Conrad

14. MOTHER'S MAIDEN NAME

Siminski, Alvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 761.5

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Prematurity
Premature rupture of membranes

19A. DATE OF OPERATION

11-1-50

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-1, 1950, to 11-1, 1950, that I last saw the
deceased alive on 11-1, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Ruth Moore

M. D.

23B. ADDRESS

Church Home & Hosp.

23C. DATE SIGNED

11-1-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL NOV 3 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

NOV 6 1950

160 c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1917

RECEIVED JAN 11 1917

1917

Dear Sir,

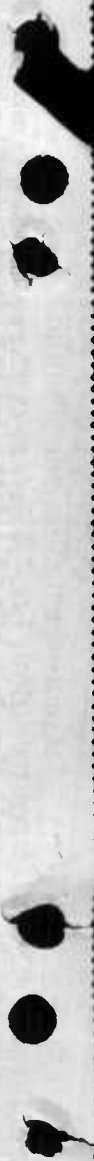
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the purchase of the land for the proposed road.

I am sorry to hear that you are having trouble with the land. I will try to help you in any way I can.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Signature]

Enclosed for you are the papers relating to the land.

Very truly yours,
J. H. [Signature]



C. 462

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 9476**

BIRTH NO. **50-23248**

1. NAME OF DECEASED (Type or Print) <i>Baby Girl Clark "B"</i>			2. DATE OF DEATH <i>10-28-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>University Hosp</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Univ Hosp</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-02</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>1811 N. Pulaski Ave.</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>B</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>10-28-50</i>	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>V.S.</i>			12. CITIZEN OF WHAT COUNTRY? <i>V.S.</i>		
13. FATHER'S NAME <i>James Clark</i>			14. MOTHER'S MAIDEN NAME <i>Ethel Fleming</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS <i>↑</i>		

18. <i>776x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>Prematurity</i> DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)					
19A. DATE OF OPERATION <i>7</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <i>10/25</i> , 19____, and that death occurred at <i>2:15 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>J. E. Furman</i>		23B. ADDRESS <i>University Hosp</i>		23C. DATE SIGNED <i>10/28</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <i>JOHN HOPKINS MEDICAL SCHOOL</i>	
24D. LOCATION (City, town, or county) <i>N.P.V. 1</i>		24E. STATE <i>1950</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 6 - 1950</i>		REGISTRAR'S SIGNATURE <i>Harry J. Williams</i>		25. FUNERAL DIRECTOR <i>Commissioner of Health</i>	
VS 150		159.0			

F

525

50 9477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9477

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELLA C. Fincham

2. DATE
OF
DEATH

11/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

327 Fonthill AVE

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

327 Fonthill AVE

c. Length of stay in Baltimore

10 years

5. SEX

FEMALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JEB 15 1883

9. AGE (in years last birthday)

67

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

N.W.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

CHARLES CORBIN

14. MOTHER'S MAIDEN NAME

Eliza McAllister

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH.

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

7 days

DUE TO

ANTECEDENT CAUSES

(B)

Hypertension

years

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

Years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 20 1950, to Nov 4 1950, that I last saw the deceased alive on Nov 4, 1950, and that death occurred at 2 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Abram Goldman M. D.

23B. ADDRESS

206 S. Gilman St.

23C. DATE SIGNED

11/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

Nov 7 1950

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL

24D. LOCATION (City, town, or county)

BALTO MD

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 6 - 1950

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

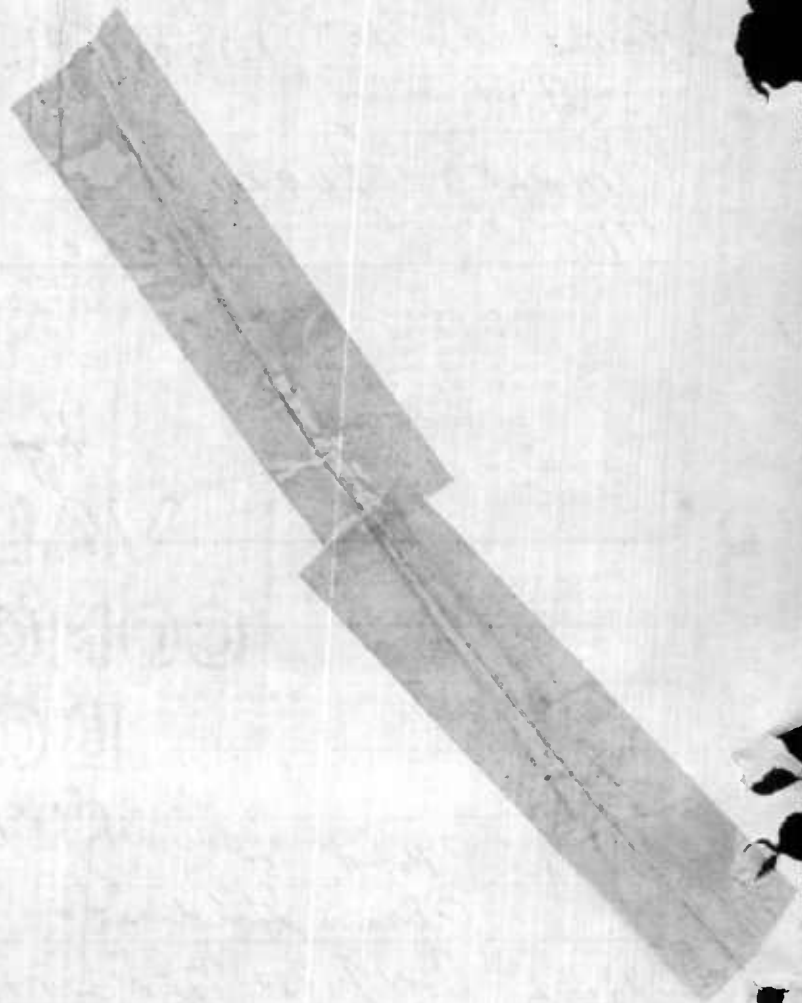
J. M. Walters

VS 150

061.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



P-610

50 9478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9478
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL J. T. PROUTY

2. DATE
OF
DEATH

4 Nov 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

42 Sinai Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

(If outside corporate limits, write R.U.R.A. and give township)

Balto

D. STREET ADDRESS (If rural, give location)

1021 Abbott Court

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10/31/1875

9. AGE (In years last birthday)

75

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

Night Watchman

10B. KIND OF BUSINESS OR INDUSTRY

West Trans. Co.

11. BIRTHPLACE (State or foreign country)

Balto Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Harry Prouty

14. MOTHER'S MAIDEN NAME

Mary E. - Edinholm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-01-1968

17. INFORMANT

Mrs. Geo. E. Bitner

ADDRESS

Phoenix Md

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Insufficiency - uremia

DUETO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute Suppurative Pyelonephritis

DUETO

(C) Benign Prostatic Hypertrophy

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardio-vasc-renal disease

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4 Nov. 1950 to 4 Nov. 1950 that I last saw the deceased alive on 4 Nov. 1950, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

George H. Gunstman

M. O.

23B. ADDRESS

Sinai Hosp.

23C. DATE SIGNED

4 Nov 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/7/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR

11-6-50

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm Cook Inc. 1217 St Paul st.

MARGIN RESERVED FOR BINDING

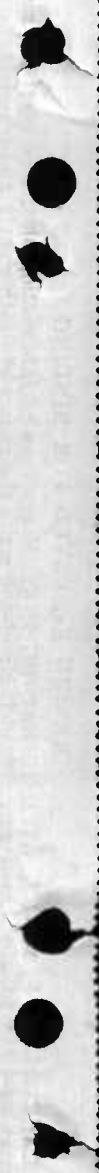
MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

30 242

CERTIFICATE OF DEATH

30 242



MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-535 50 9479

LC 143055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 9479

BIRTH NO. 50-23843

1. NAME OF DECEASED (Type or Print) Baby Girl, Snowden 'B'		2. DATE OF DEATH Nov. 4, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-32	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 2601 Spelman Road	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 2, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days 2
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Mathew McCollough		14. MOTHER'S MAIDEN NAME Jane Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records- BCH 4940 Eastern Avenue		ADDRESS	
18. 762.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Prematurity DUE TO CAUSE OF DEATH ANTECEDENT CAUSES (B) Congenital Atelectasis DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 2, 1950 to Nov. 4, 1950 that I last saw the deceased alive on Nov. 4, 1950, and that death occurred at 9:35 PM., from the causes and on the date stated above.			
23A. SIGNATURE M. D.		23B. ADDRESS 4940 Eastern Avenue	
23C. DATE SIGNED 11-7-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11-7-50	
24C. NAME OF CEMETERY OR CREMATORY B.C. H. Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR NOV 8 - 1950		REGISTRAR'S SIGNATURE William M. Williams, M.D.	
25. FUNERAL DIRECTOR		ADDRESS	

VS 150

159

BIRTH NO. 50-22113

50 9480

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9480

1. NAME OF DECEASED (Type or Print) Baby Boy Jackson			2. DATE OF DEATH October 8, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION The Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1808 Eager Street		
5. SEX Male	6. COLOR OR RACE negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH October 8, 1950		9. AGE (In years last birthday) If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Jackson			14. MOTHER'S MAIDEN NAME Mary Street		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Hospital Records		

18. 776x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Prematurity DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			DUE TO		
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from October 8, 1950 to October 8, 1950 that I last saw the deceased alive on October 8, 1950 , and that death occurred at 3:46 A. M. , from the causes and on the date stated above.					
23A. SIGNATURE <i>William Jackson</i>		23B. ADDRESS 601 N. Broadway		23C. DATE SIGNED 10-11-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county)		(State)			
DATE RECEIVED BY LOCAL REGISTRAR NOV 6 - 1950		REGISTRAR'S SIGNATURE <i>William Jackson</i>		25. FUNERAL DIRECTOR ADDRESS	

CERTIFICATE OF DEATH

STATE OF NEW YORK

1910

50

3180

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9481

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Robert Gray

2. DATE
OF
DEATH

10/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

md.

22-01

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

307 S. SHARP ST.

B. FULL NAME OF HOSPITAL OR INSTITUTION

University

c. Length of stay in Baltimore

Unknown

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Unknown

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF WHAT COUNTRY?

Unknown

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

Police Dept.

ADDRESS

18. *592 X*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) *Pneumonia, rt lower lobe*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Malnutrition & dehydration*

DUE TO

(C) *Uremia due to chr. glomeruloneph.*

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive Cardiovascular dis.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10-21, 1950* to *10-23, 1950*, that I last saw the deceased alive on *10-23, 1950* and that death occurred at *4:30 A.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Edwin M. Hubbard

M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

10-24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL OCT 30 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Commissioner of Health

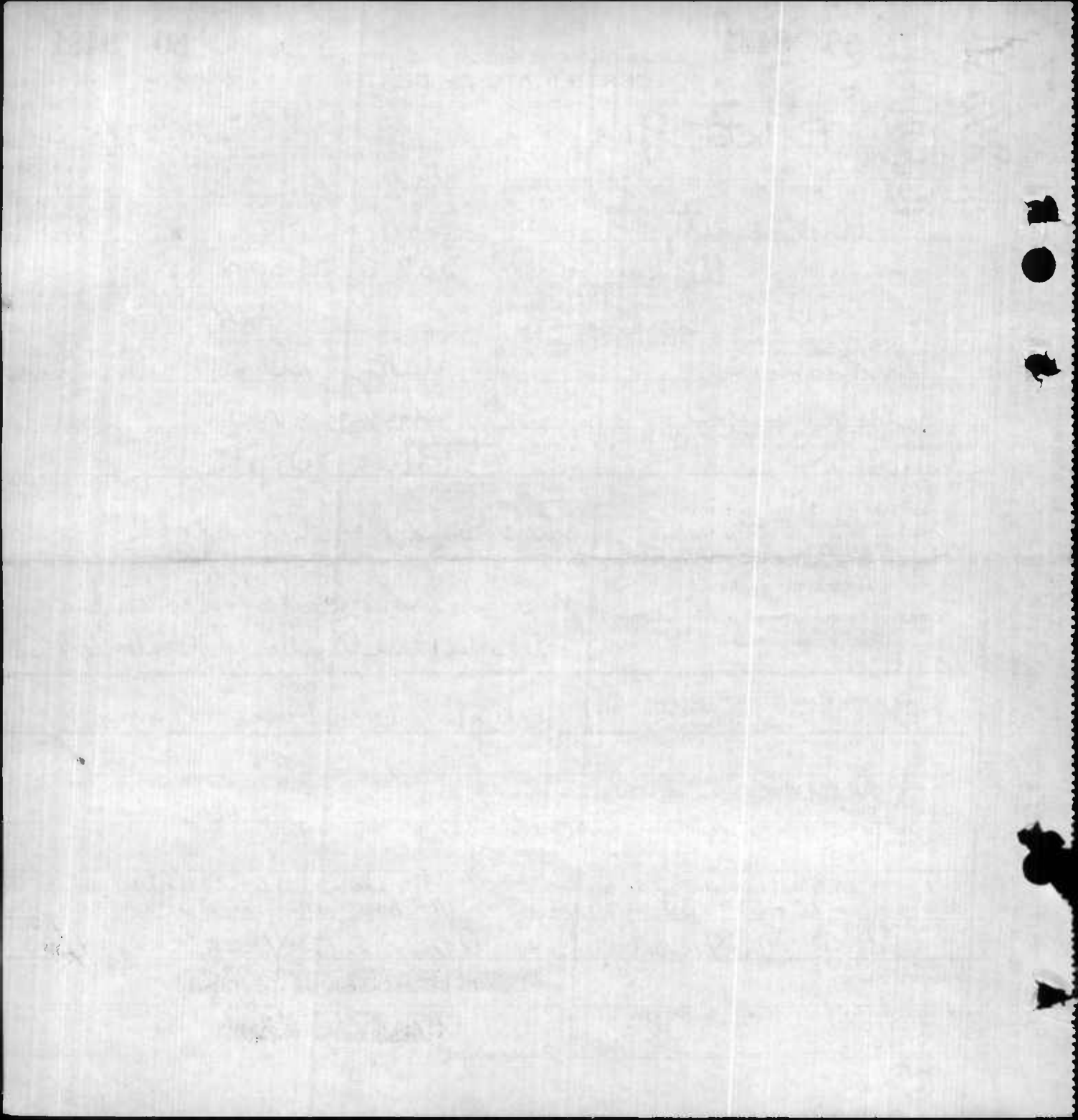
ADDRESS

VS 150

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



50 9482

50 9482

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Dorothy Rodgers

2. DATE
OF
DEATH

Oct. 27, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)
A. STATE

Md

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore 4-02

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

102 N. Pine St

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

08

9. AGE (In years
last birthday)

42

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Pendelton

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 331X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

INTRACEREBRAL HEMORRHAGE 5 MONTHS

DUE TO

ANTECEDENT CAUSES

(B)

HYPERTENSION

DUE TO

2 YEARS

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 5/22, 1950, to 10/27, 1950, that I last saw the
deceased alive on 10/27, 1950, and that death occurred at 9 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Green

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

OCT 28 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL OCT 30 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 6 - 1950

Commissioner of Health

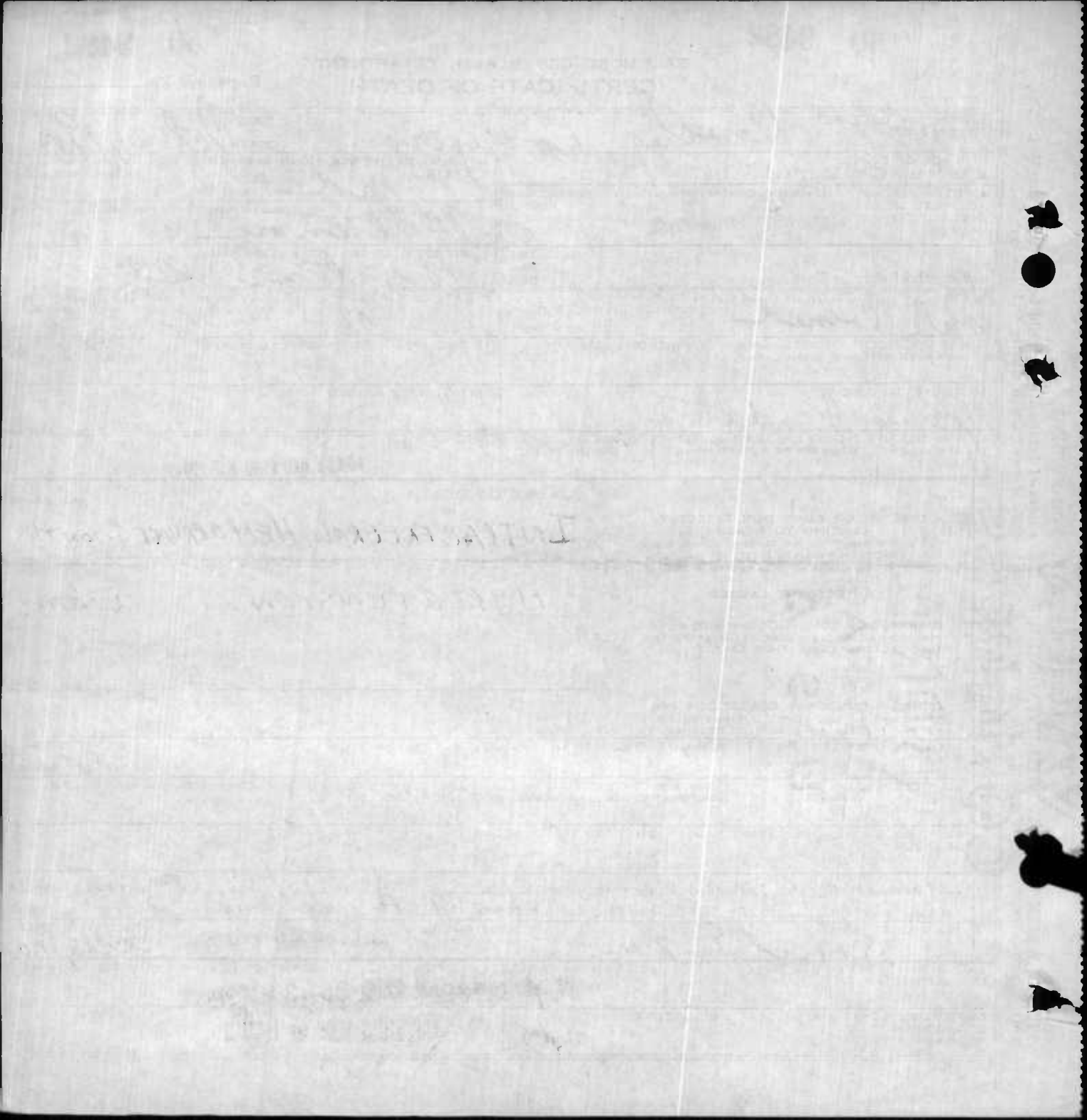
VS 150

083a

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be written clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9483

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

George Stevenson Weasner

2. DATE
OF
DEATH November 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3804 Falls Road

c. Length of stay in Baltimore

26 years

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 23, 1897

9. AGE (in years
last birthday)

53

If Under 1 Year
Months Days
If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Doorman

10B. KIND OF BUSINESS OR
INDUSTRY

Ideal Theatre

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?
U S A

13. FATHER'S NAME

William Weasner

14. MOTHER'S MAIDEN NAME

Caroline Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
215-05-1091

17. INFORMANT

Mrs. Sarah C. Weasner

ADDRESS

3804 Falls Road

18. 241 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *acute cardiac failure*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *asthma*
DUE TO
(C) *bronchiectasis*II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Dec. 13* 19*49*, to *Nov. 3* 19*50*, that I last saw the
deceased alive on *Nov. 3* 19*50*, and that death occurred at *7:45 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

Reuben Hoffman

M. D.

23B. ADDRESS

846 W. 36 B St.

23C. DATE SIGNED

NOV. 4, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 6, 1950

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Baltimore Co., Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 6 - 1950

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

Burgee Funeral Home

ADDRESS

3631 Falls Road

George Stevenson

1871

1871

1871

1871

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1871

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1871

1871

1871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9484**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)**SARAH ELIZABETH WILLIAMS**2. DATE
OF
DEATH**Nov. 3, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.B. FULL NAME OF HOME (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) **Home for the Aged of the Methodist Church****2211 W. Rogers Ave.**

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2211 W. Rogers Ave.

5. SEX

female

6. COLOR OR RACE

white7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)**single**

8. DATE OF BIRTH

Jan. 10, 18579. AGE (In years
last birthday)**93**If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)**none**10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard Clark Williams

14. MOTHER'S MAIDEN NAME

Caroline Carter15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**no**16. SOCIAL
SECURITY NO.**none**

17. INFORMANT

ADDRESS

Mrs. Mamie B. Fisher 2211 W. Rogers Ave.18. **422.1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

DUE TO

myocardial insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

arteriosclerosis

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH**5 days****15 years**

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct - 15**, 19**48**, to **Nov 2**, 19**50**, that I last saw the
deceased alive on **Nov 2**, 19**50**, and that death occurred at **3 PM**, from the causes and on the date stated above.

23A. SIGNATURE

Arthur J. Danes

M. D.

23B. ADDRESS

800 W 38th St

23C. DATE SIGNED

11-4-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)**Burial**

24B. DATE

11/6/50

24C. NAME OF CEMETERY OR CREMATORY

Balto. Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR**NOV 6 - 1950**

REGISTRAR'S SIGNATURE

Arthur J. Danes

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Dickner & Sons, Balto

0001 3 1980

0001 3 1980

0001 3 1980

0001 3 1980

0001 3 1980

0001 3 1980

0001 3 1980

0001 3 1980

0001 3 1980

0001 3 1980

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9485

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) MR. Winthrop H. Bulmer			2. DATE OF DEATH 11/3/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md. General Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pikesville 5300		
c. Length of stay in Baltimore 15 Yrs. <input type="checkbox"/> Mos. <input type="checkbox"/> Days <input type="checkbox"/>			D. STREET ADDRESS (If rural, give location) 562 Sudbrook Lane		
5. SEX M	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH June 3 '88		9. AGE (In years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Represent.		10B. KIND OF BUSINESS OR INDUSTRY Dye Co. (M)		11. BIRTHPLACE (State or foreign country) PENNA. - PHILA	
13. FATHER'S NAME William H. Bulmer			12. CITIZEN OF WHAT COUNTRY? USA.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. ?		
17. INFORMANT Mrs. Kathryn M. Bulmer			ADDRESS 562 Sudbrook Lane		

18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			CAUSE OF DEATH (A) Pulmonary infarctio DUE TO pleural + pericardial effusion (B) Arterio-sclerotic cardio- DUE TO vascular renal disease (C) _____			INTERVAL BETWEEN ONSET AND DEATH ?					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1-2 lead unio, auricular fibrillation block			19A. DATE OF OPERATION 11/3			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 10/22 , 19 50 to 11/3 , 19 50 , that I last saw the deceased alive on 11/3 , 19 50 , and that death occurred at 9:30 m., from the causes and on the date stated above.											
23A. SIGNATURE Marguerite Louise Caddle M. D.			23B. ADDRESS Maryland General Hosp			23C. DATE SIGNED 11-4-50					
24A. BURIAL (Specify) BURIAL			24B. DATE 11-6-50			24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM			24D. LOCATION (City, town, or county) (State) PIKESVILLE MD		
DATE RECEIVED BY LOCAL REGISTRAR NOV 6 - 1950			REGISTRAR'S SIGNATURE [Signature]			25. FUNERAL DIRECTOR Wm. J. Tuckner & Sons Inc.			ADDRESS North Pot Ave		

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MARGIN RESERVED FOR BINDING
PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 9486****50 9486**
BIRTH NO.

1. NAME OF DECEASED (Type or Print) DANIEL MASSEY DAVIS			2. DATE OF DEATH Nov. 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-08		
B. FULL NAME OF HOSPITAL OR INSTITUTION 3924 Edmondson Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 3924 Edmondson Ave.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 16, 1884	9. AGE (In years last birthday) 66	If Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Advertising Agency	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Daniel M. Davis			14. MOTHER'S MAIDEN NAME Sarah W. Bates		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Lillian L. Davis 3924 Edmondson Av.		

18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Auth myocardial failure DUE TO arteriosclerotic heart disease DUE TO 3 years	CAUSE OF DEATH 15 min.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION -		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY -	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> - NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? -		
22. I hereby certify that I attended the deceased from 2-26 , 19 49 , to 11-4 , 19 50 , that I last saw the deceased alive on 11-4 , 19 50 , and that death occurred at 5:04 m., from the causes and on the date stated above.				
23A. SIGNATURE H. W. Heep		23B. ADDRESS 3924 Edmondson Ave.	23C. DATE SIGNED 11-4-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/7/50	24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	24D. LOCATION (City, town, or county) Balto., Md.	(State)
DATE RECEIVED BY LOCAL REGISTRAR NOV 6 - 1950	REGISTRAR'S SIGNATURE William M. ...	25. FUNERAL DIRECTOR ADDRESS Wm. J. Tichner & Sons - Balto Md.		

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 9487**

BIRTH NO. **50 9487**

1. NAME OF DECEASED (Type or Print) Karen Sue Fornwalt			2. DATE OF DEATH 11-4-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ind B. COUNTY Frederick		
B. FULL NAME OF HOSPITAL OR INSTITUTION St Agnes Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Thurmont		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 6200		
5. SEX 3	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 1, 1950		9. AGE (In years last birthday) Months: 7 Days: 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Ralph Fornwald			14. MOTHER'S MAIDEN NAME Helin Long		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr Ralph Fornwald Thurmont		

18. 228X and E921.7 CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Aspiration of Vomitus		
(A) DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. General Anesthesia		
(B) DUE TO		
(C)		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION November 4, 1950		19B. MAJOR FINDINGS OF OPERATION Cavernous hemangioma of forearm		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) St. Agnes Hospital, Wilkens & Caton Ave
21D. TIME (Month) (Day) (Year) (Hour) November 4, 1950		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? tive period Aspiration of vomitus during post-opera

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William V. [Signature]		23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL INVESTIGATOR M.D. <input checked="" type="checkbox"/>		23C. DATE SIGNED 11-5-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov 7 1950	24C. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem.	24D. LOCATION (City, town, or county) (State) Thurmont Ind	
DATE RECEIVED BY LOCAL REGISTRAR NOV 6 - 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR M L Reager + Son		ADDRESS [Address]

query for cause for which
operation was performed,
date operation performed,
findings of operation

Examiner's case released

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9488

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>George Michael Beck</u>			2. DATE OF DEATH <u>November 4, 1950</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore <u>life</u>			D. STREET ADDRESS (If rural, give location) <u>511 N. Washington St.</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-21-69</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Beck</u>			14. MOTHER'S MAIDEN NAME <u>Suzanna ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Frank Beck 3502 Keene Avenue</u>		

18. <u>E 900.7</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <u>Hypostatic pneumonia</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <u>Fractured hip, left</u> DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <u>Senile psychosis</u>			
19A. DATE OF OPERATION <u>November 3, 1950</u>		19B. MAJOR FINDINGS OF OPERATION <u>Fractured hip</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>Accident</u>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>nursing home</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Lane Pine Crest Nursing Home-600 S. Chapelgate</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Nov. 1, 1950 ? A.m.</u>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>Slipped and fell down steps (inside)</u>	
22. I hereby certify that I attended the deceased from <u>November 1, 1950</u> to <u>November 4, 1950</u> , that I last saw the deceased alive on <u>Nov. 4, 1950</u> , and that death occurred at <u>2:20 p.m.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <u>William H. Ralston</u> M. D.		23B. ADDRESS <u>1100 N. Caroline St.</u>	23C. DATE SIGNED <u>Nov. 4, 1950</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-8-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>NOV 6 - 1950</u>		25. FUNERAL DIRECTOR ADDRESS <u>403 S. Wolfe Street</u>	

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STATE OF TEXAS
COUNTY OF DALLAS

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[Handwritten signature]

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

512
50 9489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9489

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

LENA LEIMBACH

2. DATE
OF
DEATH Nov. 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 429 N. Kenwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write BURIAL and give township)
Baltimore 20-08

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

214 S. Collins Avenue

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
single

8. DATE OF BIRTH

Aug. 14, 1895

9. AGE (In years
last birthday)

55

10 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

August Leimbach

14. MOTHER'S MAIDEN NAME

Elizabeth Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.
none

17. INFORMANT

ADDRESS

Marguerite Lambdin, 429 N. Kenwood Ave.

18. 260X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from Oct 16, 1950, to Nov 3, 1950, that I last saw the deceased alive on Nov 2, 1950, and that death occurred at 2:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Edward A. Hanger, M.D.

23B. ADDRESS

5501 Fair Ave

23C. DATE SIGNED

11-4-50.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

Nov. 6, 1950

24C. NAME OF CEMETERY OR CREMATORY

First United Evang. Church Cem. O'Donnell St., Balto. Md.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 6 - 1950

William M. ...

Schimunek Funeral Home, Inc.
2601 E. Madison St.

STATEMENT OF DEEDS

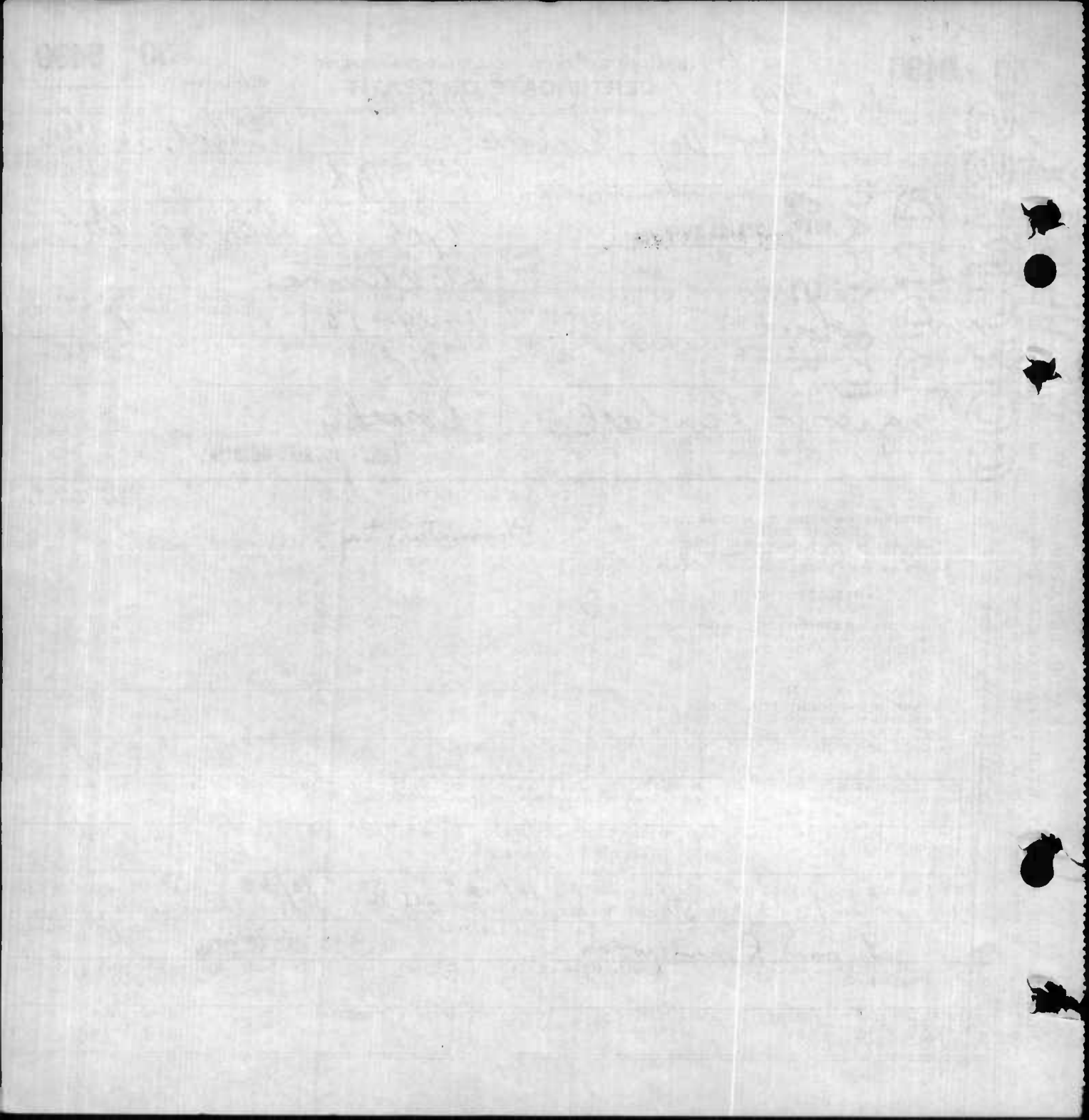
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K-534/50 9490

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				50 9490 Registered No. _____	
BIRTH NO. <u>50-23319</u>					
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Kendall</u>			2. DATE OF DEATH <u>Oct. 30, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>1706 N Spring St</u>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>Baltimore</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>10-29-50</u>	9. AGE (In years last birthday) <u>9-09</u>	If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Md</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Ongelow Kendall</u>			14. MOTHER'S MAIDEN NAME <u>Crosby</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u> ADDRESS _____		
18. <u>776x</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
CAUSE OF DEATH					
(A) <u>Prematurity</u>					
DUE TO					
ANTECEDENT CAUSES					
(B) _____					
DUE TO					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>10/30/50</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/29</u> , 19 <u>50</u> , to <u>10/30</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>50</u> , and that death occurred at <u>2:00</u> p. m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Leland Rosenberg</u> M. D.		23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY <u>Hosp Disposal</u>	24D. LOCATION (City, town, or county) (State)		
DATE RECEIVED BY LOCAL REGISTRAR <u>NOV 6 - 1950</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR ADDRESS		



H-400
50 9491
REA-142991BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9491

Registered No. _____

BIRTH NO. 50-23481

1. NAME OF DECEASED
(Type or Print)

Baby Boy Holloway-Fannie

2. DATE
OF
DEATH

Oct. 31, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE Baltimore City Hospitals

4940 Eastern Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1449 W. Hamburg Street

c. Length of stay in Baltimore

Life

5. SEX
Male6. COLOR OR RACE
Negro7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

Oct. 31, 1950

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

3 57

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Millard Ludd

14. MOTHER'S MAIDEN NAME

Fannie Mae Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Records: B. C. H. 4940 Eastern Avenue

18. 762.5

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Prematurity

DUE TO

Since Birth

ANTECEDENT CAUSES

(B) Fetal Atelectasis

DUE TO

Since Birth

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-31, 1950, to 10-31, 1950, that I last saw the
deceased alive on 10-31, 1950, and that death occurred at 8:40A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

11-2-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Cremation

24B. DATE

11-2-50

24C. NAME OF CEMETERY OR CREMATORY

B. C. H. Crematory

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

1912



W-300
50 9492BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9492

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lora White</i>		2. DATE OF DEATH <i>11-3-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>City of Baltimore</i>		C. CITY OR TOWN (If outside corporate limits, State H.R. & L. and give township) <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>654 - Saratoga St.</i>		D. STREET ADDRESS (If rural, give location) <i>654 - W. Saratoga St.</i>		E. Length of stay in Baltimore <i>10</i> Yrs. Mos. Days	
5. SEX <i>M.</i>	6. COLOR OF RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>? ? 1881</i>	9. AGE (In years last birthday) <i>69</i>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTH PLACE (State or foreign country) <i>S. C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Oden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, if known) <i>no</i> (If yes, give year and dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Percy White - 654 - Saratoga St.</i>	
18. <i>434.3</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>pericarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov 2</i> , 19 <i>50</i> , to <i>Nov 3</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Nov 2</i> , 19 <i>50</i> , and that death occurred at <i>12</i> pm., from the causes and on the date stated above.					
23A. SIGNATURE <i>L. B. Stewart</i>		23B. ADDRESS <i>632 Franklin St.</i>		23C. DATE SIGNED <i>Nov 4 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Nov. 9, 1950 Mt Calvary</i>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county) <i>-</i>		24E. LOCATION (City, town, or county) <i>-</i>		24F. LOCATION (City, town, or county) <i>-</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 6 - 1950</i>		REGISTRAR'S SIGNATURE <i>William Williams</i>		25. FUNERAL DIRECTOR <i>A. Halstead - 918 - Druid Hill Ave.</i>	

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 9493

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*William Schek*2. DATE
OF
DEATH*11-4-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

D.S.A. *Franklin Sq*

4. USUAL RESIDENCE Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write R.U.A.I. and give township)

Balto

D. STREET ADDRESS (If rural, give location)

2404 Wilkins Ave

C. Length of stay in Baltimore

*Life*Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct 27 1884

9. AGE (In years last birthday)

66

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Crop

10B. KIND OF BUSINESS OR INDUSTRY

Oil Bus. (R)

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Schek

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

213-14-412

17. INFORMANT

ADDRESS

*Mr James William 827*18. *420.0*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary Occlusion*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Atherosclerotic Heart Disease*

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William Upcott*23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

11-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Nov 8/50

24C. NAME OF CEMETERY OR CREMATORY

Louclon Park

24D. LOCATION (City, town, or county)

Balto Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Harry B. Wether 4101 Chapman

VS 151

290 6K

093d

V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

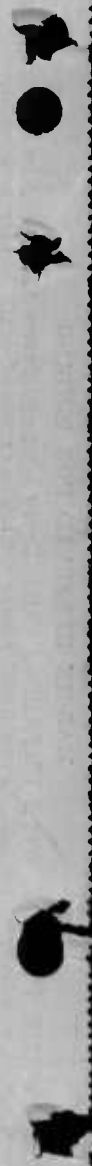
MARGIN RESERVED FOR BINDING

50-213

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

50-213

DECEASED		FATHER		MOTHER		BIRTH		DEATH	
NAME	AGE	NAME	AGE	NAME	AGE	DATE	PLACE	DATE	PLACE
<p><i>[Faint, illegible text in the body of the form, likely bleed-through from the reverse side.]</i></p>									



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9494

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) *Vincent J. McBlain*2. DATE
OF DEATH *Nov 3 50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *2564 Halpins Ave*4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE *md*

B. COUNTY _____

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTION *80 2564 Halpins Ave*C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township) *Baltimore 20-05*c. Length of stay in Baltimore *60 yr*Yrs.
Mos.
DaysD. STREET ADDRESS (If rural, give location)
2564 Halpins Ave

5. SEX

Male

6. COLOR OR RACE

*Wh*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Widow

8. DATE OF BIRTH

*Apr 20-1875*9. AGE (In years
last birthday) *75*

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Cigar maker*10B. KIND OF BUSINESS OR
INDUSTRY*Cigar mfg.*11. BIRTHPLACE (State or foreign country)
*Pa.*12. CITIZEN OF
WHAT COUNTRY?
*usa.*13. FATHER'S NAME
*St. m. McBlain*14. MOTHER'S MAIDEN NAME
*Catherine Noel*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) _____

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO. *217-16-3495*

17. INFORMANT

ADDRESS

*Sylvester McBlain 103 S Pontiac St*18. *150x*DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

CAUSE OF DEATH
*Carcinoma of esophagus*INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Sept 1, 1940* to *Nov 2, 1950*, that I last saw the
deceased alive on *Mar 2, 1950*, and that death occurred at *10 P. m.*, from the causes and on the date stated above.23A. SIGNATURE *Albert Scagnetti*

M. D.

23B. ADDRESS *1729 W. Lombard St*23C. DATE SIGNED *Nov 6 50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
*Burial*24B. DATE *Nov 7-50*24C. NAME OF CEMETERY OR CREMATORY *St Marys (Hammond)*24D. LOCATION (City, town, or county) *Baltimore Md.*

(State)

DATE RECEIVED BY
LOCAL REGISTRARREGISTRAR'S SIGNATURE *Walter William*

25. FUNERAL DIRECTOR

ADDRESS

*NOV 6 - 1950**Frank J. Smith 814 N 36 St*

50 9104

50 9104

STATE OF TEXAS

COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE

STATE OF TEXAS

IN RE: THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

OF THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

OF THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

OF THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

OF THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

OF THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

OF THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

OF THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

OF THE ESTATE OF

JOHN A. BROWN, DECEASED

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 9495
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William J. Heretick

2. DATE
OF
DEATH

11-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Balto-

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pikesville

5300

D. STREET ADDRESS (If rural, give location)

208 Reisterstown Rd.

C. Length of stay in Baltimore

11

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

2/1/1882

9. AGE (In years last birthday)

68

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Patton Sec. Industry
Cum Co. (M)

11. BIRTHPLACE (State or foreign country)

Chicago, Ill.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Stephen Heretick

14. MOTHER'S MAIDEN NAME

Angeline Tomastick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

216-03-6337

17. INFORMANT

Margaret Heretick - Pikesville Md

ADDRESS

18. *E812.4*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Generalized Arteriosclerosis*
Coronary Sclerosis & occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture left Femoral neck
Fracture of left Malleoli

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Reisterstown Road & Milford Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Oct. 24, 1950 6:15 P.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car (auto)

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William J. Heretick

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

11-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/8/50

24C. NAME OF CEMETERY OR CREMATORY

St Charles

24D. LOCATION (City, town, or county)

Pikesville Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 6 - 1950

REGISTRAR'S SIGNATURE

Thomas J. Heretick

25. FUNERAL DIRECTOR

Frank H. Newell Pikesville

ADDRESS

170c Maryland

V S 151

N-820.0

54441

170c

mayland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9496

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Rosalie
Rosalie Hodges2. DATE
OF
DEATHNov 4th 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hosp

C. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Jan 2nd 19379. AGE (In years
last birthday)

13

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Charles Hodges

14. MOTHER'S MAIDEN NAME

Madeline Stein

15. WAS DECEASED EVER IN U. S. ARMY FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs M. Stein 2411 E Lafayette Ave

18. E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Subdural Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Fracture Rt Femur

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)

Montford Ave. at Oliver Street

21D. TIME (Month) (Day) (Year) (Hour)

November 4, 1950 6.40pm

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Williams V. Lovett

23B. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

MEDICAL INVESTIGATOR

23C. DATE SIGNED

11-5-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Nov 8th 1950

24C. NAME OF CEMETERY OR CREMATORY

Balto Cem

24D. LOCATION (City, town, or county)

E. North Ave Ext

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Leok Leok 1701-03 N Patterson Park Ave

NOV 6 1950

N-854.0

170C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 9497

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LAURA J. MAXWELL

2. DATE
OF
DEATH

NOVEMBER 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Bolts

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

SINAI HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Bundab

5300

D. STREET ADDRESS (If rural, give location)

216 Patuxent Ave

c. Length of stay in Baltimore

18

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Jan 6, 1892

9. AGE (In years last birthday)

58

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bolts. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm. Sweeting

14. MOTHER'S MAIDEN NAME

Clara Stallings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Season D. Maxwell 216 Patuxent Ave

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Brachopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Cardiac Decompensation

(C) DUE TO

Atherosclerotic Heart Disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
OCTOBER 20, 1950

19B. MAJOR FINDINGS OF OPERATION

Left HYDROURETER & HYDRONEPHROSIS

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from OCTOBER 17, 1950, to NOVEMBER 4, 1950, that I last saw the deceased alive on NOVEMBER 4, 1950, and that death occurred at 6 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Wm. Robert Golden

23B. ADDRESS

SINAI HOSPITAL

23C. DATE SIGNED

Nov 4, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Buried

24B. DATE

11/7/1950

24C. NAME OF CEMETERY OR CREMATORY

Bolts. Md.

24D. LOCATION (City, town, or county)

Bolts. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 6 - 1950

REGISTRAR'S SIGNATURE

Wm. Robert Golden

25. FUNERAL DIRECTOR

ADDRESS

Walter Burke Bradley, Bundab

VS 150

MANO Robert GOLDEN

093d

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9498

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

John Owings

2. DATE
OF
DEATH

11-4-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Swai Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore, Md.

D. STREET ADDRESS (If rural, give location)

1325 Richardson St.

c. Length of stay in Baltimore

lifetime

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 29 1896

9. AGE (In years last birthday)

54

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

grain thresher

10B. KIND OF BUSINESS OR INDUSTRY

GRAIN MILL

11. BIRTHPLACE (State or foreign country)

United States

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Owings

14. MOTHER'S MAIDEN NAME

Ida Bell Likes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

1325 Richardson St.

18. *561.5*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary occlusion*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Intestinal obstruction due to Hernia*

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11-3-50

19B. MAJOR FINDINGS OF OPERATION

Hernia

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on *11-4*, 19*50*, and that death occurred at *255 A* m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Louis Fairgold

M. D.

23B. ADDRESS

Swai Hospital

23C. DATE SIGNED

11-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/7/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

(State) _____

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Glenn S. Pelt 1501 E Port Ave.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 9499

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SONNENBERG, MARY (SONNENBURG)

2. DATE
OF
DEATH

NOV. 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

Baltimore

5. FULL NAME OF (If not in hospital or institution, give street address or location)

50. BALTO. GEN. HOSP.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3506 Orchard Avenue

6. SEX

F

7. COLOR OR RACE

W

8. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

9. DATE OF BIRTH

Oct. 3, 1877

10. AGE (in years
last birthday)

73

11. Under 1 Year
Months: Days12. Under 24 Hours
Hours: Min.13A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)13B. KIND OF BUSINESS OR
INDUSTRY

Housewife

14. BIRTHPLACE (State or foreign country)

Germany

15. CITIZEN OF
WHAT COUNTRY?

16. FATHER'S NAME

?

17. MOTHER'S MAIDEN NAME

?

18. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)19. SOCIAL
SECURITY NO.

20. INFORMANT

ADDRESS

John Sonnenberg, 3506 Orchard Ave

21. 163X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) APLASTIC ANEMIA

two months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Carcinoma of lungs.

DUE TO

(C)

22. OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease

23. DATE OF OPERATION

24. MAJOR FINDINGS OF OPERATION

25. AUTOPSY?

YES ☐ NO ☒26. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH27. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)28. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)29. TIME (Month) (Day) (Year) (Hour)
OF INJURY

30. INJURY OCCURRED

31. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK32. I hereby certify that I attended the deceased from Oct. 16, 1950, to Nov. 6, 1950, that I last saw the
deceased alive on Nov. 6, 1950, and that death occurred at 12:15 p. m., from the causes and on the date stated above.

33. SIGNATURE

Martin C. Macapangan M. O.

34. ADDRESS

50. Balto. Gen. Hosp.

35. DATE SIGNED

11-6-50

36. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

37. DATE

11/6/50

38. NAME OF CEMETERY OR CREMATORY

milwaukee

39. LOCATION (City, town, or county)

milwaukee, Wisconsin

40. DATE RECEIVED BY
LOCAL REGISTRAR

NOV 6 - 1950

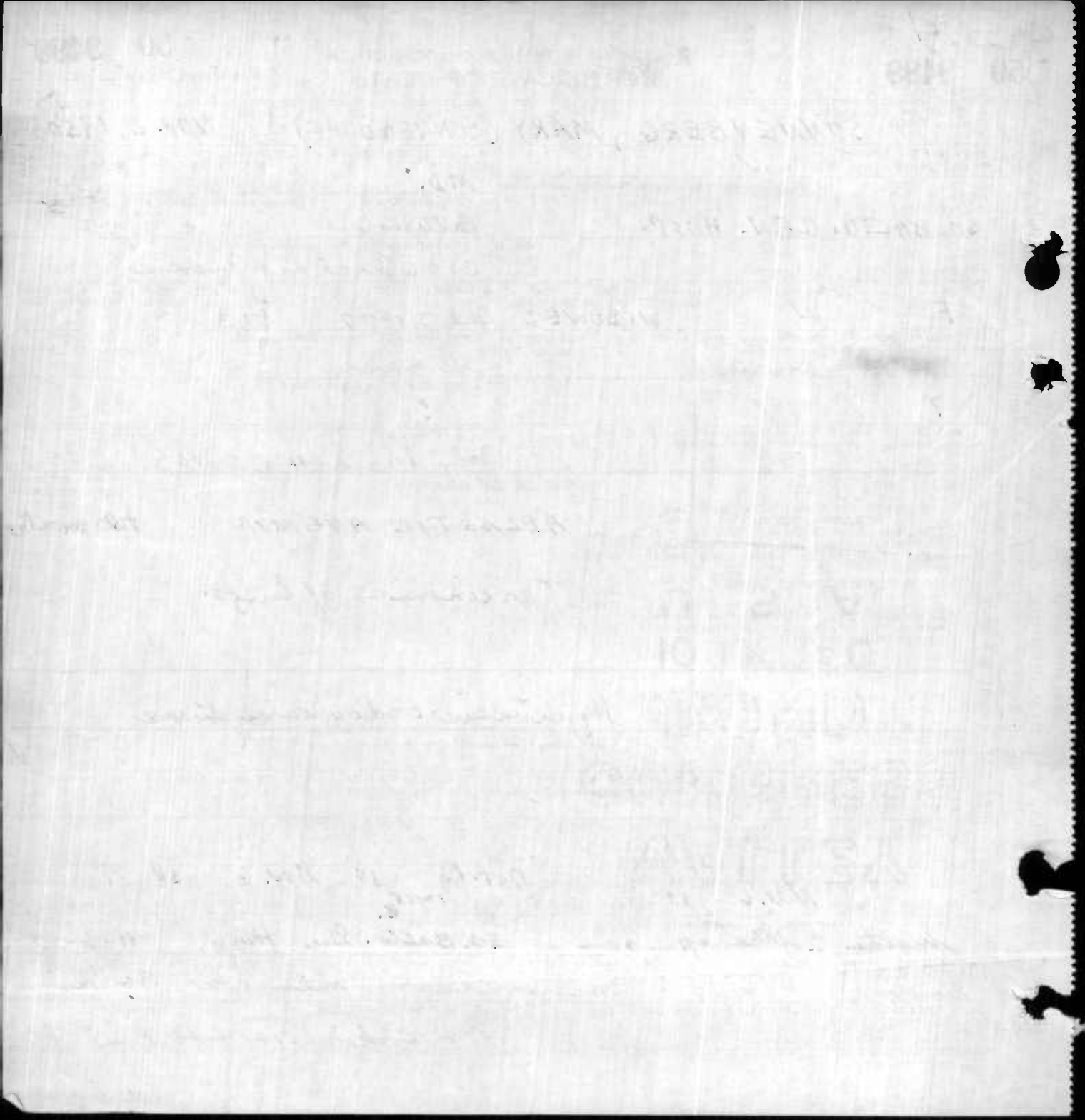
41. REGISTRAR'S SIGNATURE

William J. Williams

42. FUNERAL DIRECTOR

ADDRESS

Arm. Cook, Inc. 1217 St. Paul St.



MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 9500

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

George W. Collins

2. DATE
OF
DEATH

11/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION)

2416 Brobrown Ave. Lake Land

C. CITY OR TOWN

Balto.

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

2416 Brobrown Ave

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

11/3/1875

9. AGE (In years last birthday)

75

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Sheet Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY

Lake Insulator Co

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

(Unknown) Collins

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

Yes Spanish Amer. can

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

John Collins 3538 Beuzinger Rd

18.

155X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Terminal Broncho pneumonia

8 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Carcinoma of head of pancreas

2 yr.

(C)

DUE TO

Arterio-sclerotic Cardio-vascular Disease

8 yr

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

June 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of head of pancreas (Md. Gen. H. R. Fain)

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER- LIVING ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., at or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐NOT WHILE ☐

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1949, 19 / to Mar 4th, 1950, that I last saw the deceased alive on Mar. 3rd, 1950, and that death occurred at 1:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. E. Coughlin M.D.

23B. ADDRESS

642 N. E. Blvd

23C. DATE SIGNED

11-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/7/50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 6 - 1950

REGISTRAR'S SIGNATURE

Washington Williams

25. FUNERAL DIRECTOR

Wm. Cook Inc. 1217 St. Paul St

ADDRESS

VS 150

0469

